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THIS SUPPLEMENT CONTAINS

Statutes:

All laws specifically codified by the General Assembly of the State of Georgia through the 2015 Regular Session of the General Assembly.

Annotations of Judicial Decisions:

Case annotations reflecting decisions posted to LexisNexis® through April 3, 2015. These annotations will appear in the following traditional reporter sources: Georgia Reports; Georgia Appeals Reports; Southeastern Reporter; Supreme Court Reporter; Federal Reporter; Federal Supplement; Federal Rules Decisions; Lawyers' Edition; United States Reports; and Bankruptcy Reporter.

Annotations of Attorney General Opinions:

Constructions of the Official Code of Georgia Annotated, prior Codes of Georgia, Georgia Laws, the Constitution of Georgia, and the Constitution of the United States by the Attorney General of the State of Georgia posted to LexisNexis® through April 3, 2015.

Other Annotations:

References to:

Emory Bankruptcy Developments Journal.
Emory International Law Review.
Emory Law Journal.
Georgia Journal of International and Comparative Law.
Georgia Law Review.
Georgia State University Law Review.
John Marshall Law Review.
Mercer Law Review.
Georgia State Bar Journal.
Georgia Journal of Intellectual Property Law.
American Jurisprudence, Second Edition.
American Jurisprudence, Pleading and Practice.
American Jurisprudence, Proof of Facts.
American Jurisprudence, Trials.
Corpus Juris Secundum.
Uniform Laws Annotated.
American Law Reports, First through Sixth Series.
American Law Reports, Federal.

Tables:

In Volume 41, a Table Eleven-A comparing provisions of the 1976 Constitution of Georgia to the 1983 Constitution of Georgia and a Table Eleven-B comparing provisions of the 1983 Constitution of Georgia to the 1976 Constitution of Georgia.

An updated version of Table Fifteen which reflects legislation through the 2015 Regular Session of the General Assembly.

Indices:

A cumulative replacement index to laws codified in the 2015 supplement pamphlets and in the bound volumes of the Code.

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63. Guaranteed Asset Protection Waivers, 33-63-1 through 33-63-9.

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Law reviews. — For article, "When Do State Laws Determine ERISA Plan Benefit Rights," see 47 J. Marshall L. Rev. 145 (2014). For article, "Nondiscrimination in Insurance: The Next Chapter," see 49 Ga. L. Rev. 1 (2014). For article, "Public Officers and Employees: Employees' Insurance and Benefit Plans," see 31 Ga. St. U.L. Rev. 177 (2014).

CHAPTER 23

LICENSING

Article 1

Agents, Agencies, Subagents, Counselors, and Adjusters

Sec.

ARTICLE 1

AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS

33-23-1. Definitions.

(a) As used in this article, the term:

(1) "Adjuster" means any individual who for a fee, commission, salary, or other compensation investigates, settles, or adjusts and reports to his or her employer or principal with respect to claims arising under insurance contracts on behalf of the insurer or the insured or a person who directly supervises or manages such individual. The term "adjuster" does not include:

(A) Individuals who adjust claims arising under contracts of life or marine insurance or annuities; or

(B) An agent or a salaried employee of an agent or a salaried employee of an insurer who adjusts or assists in adjusting losses under policies issued by such agent or insurer.

(2) "Agency" means a business entity which represents one or more insurers and is engaged in the business of selling, soliciting, or negotiating insurance. Agency also means a business entity insurance producer.

(3) "Agent" means an individual appointed or employed by an insurer who sells, solicits, or negotiates insurance. Agent also means an individual insurance producer.

(3.1) "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of property insurance claims used only for portable electronics as defined in paragraph (1) of subsection (d) of Code Section 33-23-12 which:

(A) May only be utilized by a licensed independent adjuster, licensed agent, or supervised individuals operating pursuant to this paragraph;

(B) Shall comply with all claims payment requirements of the Georgia Insurance Code; and

(C) Shall be certified as compliant with this Code section by a licensed independent adjuster that is an officer of a business entity licensed under this chapter.

(4) "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(5) "Controlled business of a person" means property or casualty insurance for a person or a person's spouse; for any relative by blood or marriage within the second degree of kinship as defined by paragraph (5) of Code Section 53-4-2; for a person's employer or the firm of which a person is a member; for any officer, director, stockholder, or member of a person's employer or of any firm of which a person is a partner; for any spouse of the officer, director, employer, stockholder, or member of a person's firm; for a person's ward or employee; or for any person or in regard to any property under a person's control or supervision in any fiduciary capacity.

(6) "Counselor" means any individual who engages or advertises or holds himself or herself out as engaging in the business of counseling, advising, or rendering opinions as to the benefits promised under any contract of insurance issued or offered by any insurer or as to the terms, value, effect, advantages, or disadvantages under the contract

of insurance, other than an actuary or consultant advising insurers. When receiving a fee, commission, or other compensation for this service, such individual shall not receive any compensation from any other source on or relating to the same transaction.

(7) "Home state" means Canada, the District of Columbia, and any state or territory of the United States in which an insurance producer or adjuster maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer or adjuster.

(8) "Independent adjuster" means an adjuster representing the interest of the insurer who is not an employee of such insurer.

(9) "Insurance," except where the type of insurance is specifically stated, means all kinds of insurance other than bail bonding by individual sureties.

(10) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(10.1) "Limited subagent" means an individual licensed on behalf of a licensed agent pursuant to Code Section 33-23-12.

(11) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(12) "Person" means an individual or business entity.

(13) "Public adjuster" means any person who solicits, advertises for, or otherwise agrees to represent only a person who is insured under a policy covering fire, windstorm, water damage, and other physical damage to real and personal property other than vehicles licensed for the road, and any such representation shall be limited to the settlement of a claim or claims under the policy for damages to real and personal property, including related loss of income and living expense losses but excluding claims arising out of any motor vehicle accident, and who, for compensation on behalf of an insured:

(A) Acts or aids, solely in relation to first-party claims arising under insurance contracts that insure the real or personal property of the insured, in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

(B) Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first-party claims for losses or

damages arising out of policies of insurance that insure real or personal property; or

(C) Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy.

(14) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(15) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(16) "Subagent" means any licensed agent, except as provided in Code Section 33-23-12, who acts for or on behalf of another licensed agent in the selling of, solicitation of, or negotiation for an insurance contract or annuity contract and who has on file with the Commissioner a certificate of authority from each agent with whom the subagent places insurance. Subagent also means subproducer. The term "subagent" shall not include:

(A) An agent who places insurance with or through another agent involving 12 or fewer policies or certificates of insurance in any one calendar year; or

(B) An agent who places surplus lines insurance with or through a surplus lines broker only with respect to such surplus lines insurance.

(17) "Surplus lines broker" means an individual licensed pursuant to Code Section 33-23-37.

(b) The definitions of agent, subagent, and counselor in subsection (a) of this Code section shall not be deemed to include:

(1) An attorney at law admitted to practice in this state, when handling the collections of premiums or advising clients as to insurance as a function incidental to the practice of law or who adjusts losses which are incidental to the practice of his or her profession;

(2) Any representative of ocean marine insurers;

(3) Any representative of farmers' mutual fire insurance companies as defined in Chapter 16 of this title;

(4) A salaried employee of a credit or character reporting firm or agency not engaged in the insurance business who may, however, report to an insurer;

(5) A person acting for or as a collection agency;

(6) A person who makes the salary deductions of premiums for employees or, under a group insurance plan, a person who serves the master policyholder of group insurance in administering the details of such insurance for the employees or debtors of the master policyholder or of a firm or corporation by which the person is employed and who does not receive insurance commissions for such service; provided, further, that an administration fee not exceeding 5 percent of the premiums collected paid by the insurer to the administration office shall not be construed to be an insurance commission;

(7) Persons exempted from licensure as provided in subsection (h) of Code Section 33-23-4; or

(8) An individual who collects claim information from, or furnishes claim information to, insureds or claimants, who conducts data entry, and who enters data into an automated claims adjudication system, provided that the individual is an employee of a licensed independent adjuster or its affiliate where no more than 25 such persons are under the supervision of one licensed independent adjustor or licensed agent.

(c) In addition to paragraphs (2) through (8) of subsection (b) of this Code section, the definitions of public adjuster, independent adjuster, and adjuster in subsection (a) of this Code section shall not be deemed to include an attorney admitted to practice law in this state. (Code 1981, § 33-23-1, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1995, p. 1011, §§ 1, 2; Ga. L. 1999, p. 878, § 2; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 1/SB 113; Ga. L. 2012, p. 1350, §§ 3, 4, 5/HB 1067; Ga. L. 2012, p. 1040, §§ 4, 5, 6/SB 203; Ga. L. 2014, p. 181, §§ 1, 2/HB 610.)

The 2014 amendment, effective July 1, 2014, in subsection (a), added ", and who, for compensation on behalf of an insured:" at the end of paragraph (a)(13), and added subparagraphs (a)(13)(A) through (a)(13)(C); in subsection (b), in the introductory language, substituted "and counselor" for "counselor, and adjuster", and, in paragraph (b)(1), deleted ", from time to time," following "practice of law or who"; and added subsection (c).

33-23-4. License required; restrictions on payment or receipt of commissions; positions indirectly related to sale, solicitation, or negotiation of insurance excluded from licensing requirements.

(a)(1) A person shall not sell, solicit, or negotiate insurance in this state for any class or classes of insurance unless the person is

licensed for that line of authority in accordance with this chapter and applicable regulations.

(2) Any individual who sells, solicits, or negotiates insurance in this state shall be licensed as an agent.

(3) Any business entity that sells, solicits, or negotiates insurance in this state shall be licensed as an agency.

(4) Any individual defined as an adjuster under paragraph (1) of subsection (a) of Code Section 33-23-1 who for a fee, commission, salary, or other compensation investigates, settles, or adjusts claims arising under insurance contracts on behalf of the insurer or the insured shall be licensed as either an independent adjuster or a public adjuster.

(b) No insurer or agent doing business in this state shall pay, directly or indirectly, any commissions or any other valuable consideration to any person for services as an agent, subagent, or adjuster within this state, unless such person is duly licensed in accordance with this article.

(c) An insurer may pay a commission or other valuable consideration to a licensed insurance agency in which all employees, stockholders, directors, or officers who sell, solicit, or negotiate insurance contracts are qualified insurance agents, limited subagents, or counselors holding currently valid licenses as required by the laws of this state; and an agent, limited subagent, or counselor may share any commission or other valuable consideration with such a licensed insurance agency.

(d) No person other than a duly licensed adjuster, agent, limited subagent, or counselor shall pay or accept any commission or other valuable consideration except as provided in subsections (b) and (c) of this Code section.

(e) This Code section shall not prevent the payment or receipt of renewal or deferred commissions by any agency or a person on the grounds that the licensee has ceased to be an agent, limited subagent, or counselor nor prevent the receipt or payment of any commission by an individual who has been issued a temporary license pursuant to this chapter.

(f) Any individual who has been licensed as an agent for ten consecutive years or more and who does not perform any of the functions specified in paragraph (3) of subsection (a) of Code Section 33-23-1 other than receipt of renewal or deferred commissions shall be exempt from the requirement to maintain at least one certificate of authority; provided, however, that if such individual wishes to again perform any of the other functions specified in said paragraph, such individual must obtain approval from the Commissioner and comply

with the requirements of this chapter and applicable rules and regulations, including without limitation the requirements for certificate of authority.

(g) Any person who willfully violates this Code section shall be guilty of a misdemeanor and, upon conviction thereof, shall be subject to punishment as provided in Code Section 17-10-3, relating to punishment for misdemeanors.

(h)(1) Nothing in this article shall be construed to require an insurer to obtain an insurance agent's license. As used in this Code section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

(2) A license as an insurance agent shall not be required of the following:

(A) An officer, director, or employee of an insurer or of an insurance agent or agency, provided that the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this state and:

(i) The officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance;

(ii) The officer, director, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(iii) The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance agents where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance;

(B) A person who meets the criteria set forth in paragraph (6) of subsection (b) of Code Section 33-23-1;

(C) An employer or association or its officers, directors, or employees or the trustees of an employee trust plan to the extent that the employers, officers, employees, directors, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, so long as the

employers, associations, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(D) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks or in the supervision of the training of insurance agents and who are not individually engaged in the sale, solicitation, or negotiation of insurance;

(E) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state;

(F) A person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that the person is otherwise licensed as an insurance agent to sell, solicit, or negotiate insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(G) A salaried, full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission. (Code 1981, § 33-23-4, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 705, § 9; Ga. L. 1997, p. 1296, § 4; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 2/SB 113; Ga. L. 2014, p. 181, § 3/HB 610.)

The 2014 amendment, effective July 1, 2014, in subsection (a), substituted "state shall" for "state must" in paragraphs (a)(2) and (a)(3), and added paragraph (a)(4).

33-23-12. Limited licenses.

(a) Except as provided in subsection (b) of this Code section for credit insurance licenses, subsection (c) of this Code section for rental companies, subsection (d) of this Code section for portable electronics, and subsection (f) of this Code section for travel insurance, the Commissioner may provide by rule or regulation for licenses which are limited in scope to specific lines or sublines of insurance.

(b)(1) Licenses shall be issued to individuals for the purpose of writing credit insurance as provided in this subsection.

(2) Resident applicants must be sponsored by an insurer authorized to write credit insurance in this state, and the applicant must certify that he or she has read and understands the provisions of this title and regulations promulgated pursuant to this title which are pertinent to credit insurance in this state.

(3) Nonresident applicants must follow the appointment process set forth in subsection (g) of Code Section 33-23-16.

(4) No prelicensing education or prelicensing examination shall be required for issuance of such license, and the insurer shall certify that the licensee has completed a minimum of five hours of self-study in credit insurance subjects.

(5) The lines or sublines of insurance included in the scope of authority of credit insurance licenses issued under this Code section shall include, but not be limited to, the following:

(A) Credit life and credit accident and sickness insurance;

(B) Credit casualty insurance;

(C) Credit property insurance;

(D) Credit unemployment insurance;

(E) Accidental death and dismemberment insurance;

(F) Nonfiling or nonrecording insurance;

(G) Vendors' single interest insurance; and

(H) Any other lines or sublines of insurance which may become accepted as credit insurance by the insurance and lending industries unless otherwise disapproved by the Commissioner.

(c)(1) As used in this subsection, the term:

(A) "Limited licensee" means a person or entity authorized to sell certain coverages relating to the rental of vehicles pursuant to the provisions of this subsection.

(B) "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease.

(C) "Rental company" means any person or entity in the business of providing primarily private passenger vehicles to the public under a rental agreement for a period not to exceed 90 days.

(D) "Rental period" means the term of the rental agreement.

(E) "Renter" means any person obtaining the use of a vehicle from a rental company under the terms of a rental agreement for a period not to exceed 90 days.

(F) "Vehicle" or "rental vehicle" means a motor vehicle of the private passenger type, including passenger vans, minivans, and sport utility vehicles, and of the cargo type, including cargo vans, pick-up trucks, and trucks with a gross vehicle weight of less than 26,000 pounds and which do not require the operator to possess a commercial driver's license.

(2) The Commissioner may issue to a rental company that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance through a licensed insurer in connection with the rental of vehicles.

(3) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for a limited license in such form or forms, and supplements thereto, and containing such information as the Commissioner may prescribe.

(4) In the event that any provision of this subsection is violated by a limited licensee, the Commissioner may:

(A) After notice and a hearing, revoke or suspend a limited license issued under this subsection in accordance with the provisions of Code Sections 33-23-21 and 33-23-22; or

(B) After notice and a hearing, impose such other penalties, including suspending the transaction of insurance at specific rental locations where violations of this subsection have occurred, as the Commissioner deems to be necessary or convenient to carry out the purposes of this subsection.

(5) The rental company licensed pursuant to paragraph (2) of this subsection may only offer or sell insurance through licensed insurers in connection with and incidental to the rental of vehicles, whether at the rental office or by preselection of coverage in an individual, master, corporate, or group rental agreement, in any of the following general categories:

(A) Personal accident insurance covering the risks of travel, including, but not limited to, accident and health insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs during the rental period;

(B) Liability insurance, which, at the exclusive option of the rental company, may include uninsured and underinsured motorist

coverage, whether offered separately or in combination with other liability insurance, that provides coverage, as applicable, to renters and other authorized drivers of rental vehicles for liability arising from the operation of the rental vehicle;

(C) Personal effects insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for the loss of, or damage to, personal effects that occurs during the rental period;

(D) Roadside assistance and emergency sickness protection programs; and

(E) Any other travel or vehicle related coverage that a rental company offers in connection with and incidental to the rental of vehicles.

(6) No insurance shall be offered by a limited licensee pursuant to this subsection unless:

(A) The rental period of the rental agreement does not exceed 90 consecutive days;

(B) At every rental location where rental agreements are executed, brochures or other written materials are readily available to the prospective renter that:

(i) Summarize clearly and correctly the material terms of coverage offered to renters, including the identity of the insurer;

(ii) Disclose that such policies offered by the rental company may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(iii) State that the purchase by the renter of the kinds of coverage specified in this subsection is not required in order to rent a vehicle; and

(iv) Describe the process for filing a claim in the event the renter elects to purchase coverage and in the event of a claim;

(C) Evidence of coverage on the face of the rental agreement is disclosed to every renter who elects to purchase such coverage.

(7) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(8) Each rental company licensed pursuant to this subsection shall provide a training program in which employees being trained by a

licensed instructor receive basic insurance instruction about the kinds of coverage specified in this subsection and offered for purchase by prospective renters of rental vehicles. Additionally, each rental company shall provide for such employees two hours of continuing education courses annually to be taught by a licensed instructor. A rental company shall certify that, prior to offering such coverages, each employee has received such instruction.

(9) Notwithstanding any other provision of this subsection or any rule adopted by the Commissioner, a limited licensee pursuant to this subsection shall not be required to treat moneys collected from renters purchasing such insurance when renting vehicles as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental transaction. The sale of insurance not in conjunction with a rental transaction shall not be permitted.

(10) No limited licensee under this subsection shall advertise, represent, or otherwise hold itself or any of its employees out as licensed insurers, insurance agents, or insurance brokers.

(d)(1) As used in this subsection, the term:

(A) "Customer" means a person who purchases portable electronics or services.

(B) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(C) "Location" means any physical location in the State of Georgia or any website, call center site, or similar location directed to residents of the State of Georgia.

(D) "Portable electronics" means handsets, pagers, personal digital assistants, portable computers, automatic answering devices, cellular telephones, batteries, and other similar devices and their accessories and includes services related to the use of such devices, including, but not limited to, individual customer access to a wireless network.

(E) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following causes of loss: loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar causes of loss. Such term shall not include a service contract or extended warranty providing coverage limited to the repair, replacement, or maintenance of property in cases of operational or structural

failure due to a defect in materials, workmanship, accidental damage from handling power surges, or normal wear and tear.

(F) "Portable electronics transaction" means the sale or lease of portable electronics by a vendor to a customer or the sale of a service related to the use of portable electronics by a vendor to a customer.

(G) "Supervising entity" means a business entity that is a licensed insurer, or insurance producer that is authorized by licensed insurer, to supervise the administration of a portable electronics insurance program.

(H) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(2) The commissioner may issue to a retail vendor of portable electronics that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell portable electronics insurance policies.

(3) A limited license issued under this subsection shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to customers at each location where the vendor engages in portable electronics transactions.

(4) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the commissioner and with ten days notice to the supervising entity, the registry shall be open to inspection and examination by the commissioner during regular business hours of the supervising entity.

(5) The sale of such insurance policies shall be limited to sales in connection with the sale of or provision of service for portable electronics by the retail vendor.

(6) At every location where portable electronics insurance is offered to customers, brochures or other written materials shall be made available to a prospective customer which:

(A) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(B) Summarize the material terms of the insurance coverage, including:

(i) The identity of the insurer;

(ii) The identity of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the coverage; and

(v) Key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with a similar make and model or with reconditioned or nonoriginal manufacturer parts or equipment;

(C) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(D) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund of any applicable unearned premium.

(7) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers. Coverage under portable electronics insurance shall be primary to any other insurance.

(8) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

(9) Notwithstanding any other provision of law, employees or authorized representatives of a vendor of portable electronics shall not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage but may receive compensation for activities under the limited license which are incidental to their overall compensation.

(10) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services, shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account, provided that the vendor is authorized by the insurer to hold such funds in an alternative

manner and remits such amounts to the supervising entity within 60 days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

(11) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for such limited license or licenses in a form and manner prescribed by the Commissioner. The application shall provide:

(A) The name, residence address, and other information required by the Commissioner of an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this subsection;

(B) If the vendor derives more than 50 percent of its revenue from the sale of portable electronics insurance, the information required by subparagraph (A) of this paragraph for all officers, directors, and shareholders of record having beneficial ownership of 10 percent or more of any class of securities registered under the federal securities law; and

(C) The location of the applicant's home office.

(12) The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this Code section, provided that the supervising entity supervises the administration of a training program in which employees and authorized representatives of a vendor shall be trained and receive basic insurance instruction about the kind of coverage authorized in this subsection and offered for purchase by prospective purchasers. The training required by this subsection may be provided in electronic form. However, if provided in electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance that is conducted and overseen by a licensed instructor.

(13) No prelicensing examination shall be required for issuance of such license.

(14) If a vendor or its employee or authorized representative violates any provision of this subsection, the commissioner may impose any of the following penalties:

(A) After notice and hearing, fines not to exceed $500.00 per violation or $5,000.00 in the aggregate for such conduct;

(B) After notice and hearing, other penalties that the commissioner deems necessary and reasonable to carry out the purpose of this article, including:

(i) Suspending the privilege of transacting portable electronics insurance pursuant to this subsection at specific business locations where violations have occurred; and

(ii) Suspending or revoking the ability of individual employees or authorized representatives to act under the license;

(15) Notwithstanding any other provision of law:

(A) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least 60 days' notice;

(B) If the insurer changes the terms and conditions, then the insurer shall provide the vendor with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of material changes;

(C) Notwithstanding paragraph (15) of subsection (a) of this Code section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 15 days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim;

(D) Notwithstanding paragraph (15) of subsection (a) of this Code section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(i) For nonpayment of premium;

(ii) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(iii) If the enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer; and

(E) Where a portable electronics insurance policy is terminated by a policyholder, the vendor shall mail or deliver written notice to

each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least 30 days prior to the termination.

(16) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to this subsection or is otherwise required by law, it shall be in writing and sent within the notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means as set forth in this subparagraph. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last known mailing addresses on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's electronic mail address specified for such purpose and to its affected enrolled customers' last known electronic mail address as provided by each enrolled customer to the insurer or vendor of portable electronics, as the case may be. For purposes of this paragraph, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics, as the case may be, shall be deemed as consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice or correspondence was sent.

(17) Notice or correspondence required by this subsection or otherwise required by law may be sent on behalf of an insurer or vendor, as the case may be, by the supervising entity appointed by the insurer.

(e)(1) As used in this subsection, the term:

(A) "Limited licensee" means an owner authorized to act as an agent of an insurance provider for purposes of selling certain insurance coverages for personal property maintained in self-service storage facilities pursuant to the provisions of this subsection.

(B) "Occupant" means a person, his or her sublessee, successor, or assign entitled to the use of the storage space at a self-service storage facility under a rental agreement, to the exclusion of others.

(C) "Owner" means the owner, operator, lessor, or sublessor of a self-service storage facility, his or her agent, or any other person authorized by him or her to manage the self-service storage facility or to receive rent from an occupant under a rental agreement.

(D) "Personal property" means movable property not affixed to land and includes, but is not limited to, goods, wares, merchandise, motor vehicles, watercraft, and household items and furnishings.

(E) "Rental agreement" means any agreement or lease, written or oral, that establishes or modifies the terms, conditions, rules, or any other provisions concerning the use and occupancy of a self-service storage facility.

(F) "Self-service storage facility" means any real property designed and used for the purpose of renting or leasing individual storage space to occupants who are to have access to such for the purpose of storing and removing personal property. No occupant shall use a self-service storage facility for residential purposes. A self-service storage facility is not a warehouse within the meaning of Article 1 of Chapter 4 of Title 10, the "Georgia State Warehouse Act." A self-service storage facility is not a safe-deposit box or vault maintained by banks, trust companies, or other financial entities.

(2) The Commissioner may issue to an owner that is in compliance with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance through a licensed insurer in connection with a self-service storage facility.

(3) A limited licensee shall be authorized to offer or sell insurance on behalf of a licensed insurer only in connection with a rental agreement and only for either an individual policy issued to an individual occupant or as a group policy for occupants for personal property insurance. A limited licensee shall only be authorized to provide to occupants insurance coverage for:

(A) The loss of or damage to personal property stored at a self-service storage facility where the loss or damage occurs at such self-service storage facility during the occupant's rental agreement; or

(B) Such other loss directly related to an occupant's rental agreement.

(4) No insurance shall be issued pursuant to this subsection unless the limited licensee provides to a prospective occupant written material that:

(A) Provides a summary of the terms of insurance coverage, including the identity of the insurer;

(B) Conspicuously discloses that the policy of insurance may provide a duplication of coverage already provided by an existing policy of insurance;

(C) Describes the process for filing a claim in the event the occupant elects to purchase coverage and experiences a covered loss;

(D) Provides information regarding the price, deductible, benefits, exclusions, conditions, and any other limitations of such policy;

(E) States that the limited licensee is not authorized to evaluate the adequacy of the occupant's existing insurance coverages, unless such limited licensee is otherwise licensed; and

(F) States that the occupant may cancel the insurance at any time, and any unearned premium will be refunded in accordance with applicable law.

(5) Notwithstanding any other provision of this subsection or any rule adopted by the Commissioner, a limited licensee licensed pursuant to this subsection shall not be required to treat moneys collected from occupants under rental agreements as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental agreement. The sale of insurance not in conjunction with a rental agreement shall not be permitted.

(6) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(7) Each owner licensed pursuant to this subsection shall provide a training program in which employees and authorized representatives of such owner shall be trained by a licensed instructor and receive basic insurance instruction about the kind of coverage authorized in this subsection and offered for purchase by prospective occupants.

(8) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for a limited license in such form or forms, and supplements thereto, and containing such information as the Commissioner may prescribe.

(9) In the event that any provision of this title is violated by a limited licensee, or an employee of a limited licensee, the limited licensee shall be subject to all penalties, fines, criminal sanctions, and other actions authorized by this title.

(10) No prelicensing examination shall be required for issuance of a limited license pursuant to this subsection.

(f)(1) As used in this subsection, the term:

(A) "Limited licensee" means a person or entity authorized to sell certain coverages related to travel pursuant to the provisions of this subsection.

(B) "Limited lines travel insurance producer" means a:

(i) Licensed managing general underwriter;

(ii) Licensed managing general agent or third-party administrator; or

(iii) Licensed insurance producer, including a limited licensee, designated by an insurer as the travel insurance supervising entity as set forth in division (2)(C)(iii) of this subsection.

(C) "Offer and disseminate" means providing general information, including a description of the coverage and price, as well as processing the application, collecting premiums, and performing other nonlicensable activities permitted by this state.

(D) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including, but not limited to:

(i) Interruption or cancellation of trip or event;

(ii) Loss of baggage or personal effects;

(iii) Damage to accommodations or rental vehicles; or

(iv) Sickness, accident, disability, or death occurring during travel.

Travel insurance shall not include major medical plans which provide comprehensive medical protection for travelers with trips lasting six months or longer, including, but not limited to, those working overseas as an expatriate or military personnel being deployed.

(E) "Travel retailer" means a business entity that makes, arranges, or offers travel services and that may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

(2)(A) Notwithstanding any other provision of law, the Commissioner may issue to an individual or business entity that has complied with the requirements of this subsection a limited lines travel insurance producer license which authorizes the limited lines travel insurance producer to sell, solicit, or negotiate travel insurance through a licensed insurer.

(B) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an applica-

tion for such limited license in a form and manner prescribed by the Commissioner.

(C) Notwithstanding any other provision of law, a travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity license only if the following conditions are met:

(i) The limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

(I) A description of the material terms or the actual material terms of the insurance coverage;

(II) A description of the process for filing a claim;

(III) A description of the review or cancellation process for the travel insurance policy; and

(IV) The identity and contact information of the insurer and limited lines travel insurance producer;

(ii) At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register on a form prescribed by the Commissioner of each travel retailer that offers travel insurance on the limited lines travel insurance producer's behalf. The register shall be maintained and updated by the limited lines travel insurance producer and shall include the name, address, and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations and the travel retailer's federal tax identification number. The limited lines travel insurance producer shall submit such register to the Insurance Department upon reasonable request. The limited lines travel insurance producer shall also certify that the travel retailer registered complies with 18 U.S.C. Section 1033;

(iii) The limited lines travel insurance producer shall designate one of its employees who is a licensed individual producer as the person responsible for the limited lines travel insurance producer's compliance with the travel insurance laws, rules and regulations of this state;

(iv) The employee designated as provided in division (iii) of this subparagraph, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations shall comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer;

(v) The limited lines travel insurance producer shall pay all applicable insurance producer licensing fees as set forth in applicable state law;

(vi) The limited lines travel insurance producer shall require each employee or authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the Commissioner. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers; and

(vii) No prelicensing examination or continuing education shall be required for issuance of a limited license pursuant to this subsection.

(D) Any travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that:

(i) Provide the identity and contact information of the insurer and the limited lines travel insurance producer;

(ii) Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(iii) Explain that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(E) A travel retailer employee or authorized representative that is not licensed as an insurance producer shall not:

(i) Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

(ii) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(iii) Hold itself out as a licensed insurer, licensed producer, or insurance expert.

(3) Notwithstanding any other provision of law, a travel retailer whose insurance related activities, and those of its employees or authorized representatives, are limited to offering and disseminating

travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this subsection shall be authorized to do so and receive related compensation upon registration by the limited lines travel insurance producer as provided in subparagraph (C) of paragraph (2) of this subsection.

(4) Travel insurance may be provided under an individual policy or under a group or master policy.

(5) As the insurer designee, the limited lines travel insurance producer shall be responsible for the acts of the travel retailer and authorized representative and shall use reasonable means to ensure compliance by the travel retailer with this subsection.

(6) The limited lines travel insurance producer and any travel retailer or authorized representative offering and disseminating travel insurance under the limited lines travel insurance producer's license shall be subject to the unfair trade practices provisions under Article 1 of Chapter 6 of this title and to the other provisions of this article relating to insurance producers. (Code 1981, § 33-23-12, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1995, p. 437, § 3; Ga. L. 1999, p. 878, § 4; Ga. L. 2001, p. 4, § 33; Ga. L. 2001, p. 925, § 1; Ga. L. 2002, p. 1047, § 1; Ga. L. 2008, p. 1076, § 7/SB 113; Ga. L. 2012, p. 757, § 1/HB 463; Ga. L. 2012, p. 1040, §§ 2, 3/SB 203; Ga. L. 2012, p. 1350, §§ 1, 2/HB 1067; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2013, p. 742, §§ 1, 2/SB 234; Ga. L. 2014, p. 866, § 33/SB 340.)

The 2014 amendment, effective April 29, 2014, part of an Act to revise, modernize, and correct the Code, revised capitalization in subsection (a).

33-23-43. Authority of adjusters; penalty for violation.

(a) An adjuster licensed as both an independent and a public adjuster shall not represent both the insurer and the insured in the same transaction.

(b) An adjuster shall have authority under his or her license only to investigate, settle, or adjust and report to his or her principal upon claims arising under insurance contracts on behalf of insurers only if licensed as an independent adjuster or on behalf of insureds only if licensed as a public adjuster.

(c) No public adjuster, at any time, shall knowingly:

(1) Misrepresent to an insured that he or she is required to hire an independent or public adjuster to help the insured meet his or her obligations under his or her policy;

(2) Accept or agree to accept any money or other compensation from an attorney or any person acting on behalf of an attorney which

the adjuster knows or should reasonably know is payment for the suggestion or advice by the adjuster to seek the services of the attorney or for the referral of any portion of a person's claim to the attorney;

(3) Hire or procure another to do any act prohibited by this subsection;

(4) Advertise or promise to pay or rebate all or any portion of any insurance deductible as an inducement to the sale of goods or services. As used in this paragraph, the term "promise to pay or rebate" includes:

(A) Granting any allowance or offering any discount against the fees to be charged, including, but not limited to, an allowance or discount in return for displaying a sign or other advertisement at the insured's premises; or

(B) Paying the insured or any person directly or indirectly associated with the property any form of compensation, gift, prize, bonus, coupon, credit, referral fee, or other item of monetary value for any reason;

(5) Misrepresent to a claimant that he or she is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or as an independent adjuster, unless appointed by an insurer in writing to act on the insurer's behalf for that specific claim or purpose. A licensed public adjuster shall not charge a claimant a fee for adjusting a claim when he or she is appointed by the insurer for that specific claim or purpose and the appointment is accepted by the public adjuster;

(6) Solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence as defined in the insured's insurance contract;

(7) Have a direct or indirect financial interest in any aspect of a claim other than the salary, fee, commission, or other consideration established in a written contract with the insured which shall incorporate all of the conditions and provisions set out in Code Section 33-23-43.1;

(8) Charge to or collect from an insured any amount, other than reasonable compensation for services rendered based on time spent and expenses incurred, in any transaction where the insurer either pays or commits in writing to pay the policy limit or limits for all coverage under the insured's policy within three business days after the loss is reported to the insurer;

(9) Misrepresent to an insured or insurer that he or she is an attorney authorized by law to provide legal advice and services or

that a policy covers a loss or losses outside the scope of the coverage provided by the insurance contract;

(10) Permit an unlicensed employee or representative of the adjuster to conduct business for which a license is required; or

(11) Hire or procure another to do any act prohibited by this subsection.

(d) For purposes of subsection (c) of this Code section, the term "public adjuster" shall include licensed public adjusters as defined by Code Section 33-23-1, persons representing themselves to be public adjusters who are not properly licensed by the Commissioner, and persons committing any act under paragraph (4) of subsection (c) of this Code section.

(e) Any person who violates any provision of subsection (c) of this Code section shall be guilty of a misdemeanor and such violation shall be grounds for suspension or revocation of licenses under this chapter. (Code 1981, § 33-23-43, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2011, p. 613, § 2/HB 423; Ga. L. 2014, p. 181, § 4/HB 610; Ga. L. 2015, p. 5, § 33/HB 90.)

The 2014 amendment, effective July 1, 2014, substituted the present provisions of paragraph (c)(1) for the former provisions, which read: "Suggest or advise the employment of or name for employment a specific attorney or attorneys to represent a person in any matter relating to a person's potential claims, including any motor vehicle accident claims for personal injury, loss of consortium, property damages, or other special damages"; deleted "or" at the end of paragraph (c)(3); in paragraph (c)(4), added a colon following "includes" in the introductory language, in subparagraph (c)(4)(A), substituted "Granting" for "granting" and substituted a semicolon for a comma at the end, and, in subparagraph (c)(4)(B), substituted "Paying" for "paying" and added a semicolon at the end; and added paragraphs (c)(5) through (c)(11).

The 2015 amendment, effective March 13, 2015, part of an Act to revise, modernize, and correct the Code, substituted "paragraph" for "subsection" in the introductory language of paragraph (c)(4).

33-23-43.1. Requirements for public adjuster contracts.

(a) Public adjusters shall ensure that all contracts for their services are in writing, prominently captioned and titled "Public Adjuster Contract," and contain the following:

(1) Legible full name of the public adjuster signing the contract, as specified on the license issued by the Department of Insurance, and attestation language that the public adjuster is fully bonded pursuant to state law;

(2) Permanent home state business address and contact information of the public adjuster, including e-mail address;

(3) The public adjuster's Department of Insurance license number and a statement that the license is valid and in full force and effect as of the date the contract is signed;

(4) The insured's full name and street address;

(5) A description of the loss and its location, if applicable;

(6) A description of services to be provided to the insured;

(7) Signatures of the public adjuster and the insured;

(8) The date the contract was signed by the public adjuster, and the date the contract was signed by the insured;

(9) A statement of the fee, compensation, or other considerations that the public adjuster is to receive for services, including a listing of typical costs and expenses for which the public adjuster is to be reimbursed; and

(10) A statement prominently captioned in a minimum 12 point font that contains the following:

(A) Any direct or indirect interest in or compensation by any construction firm, salvage firm, building appraisal firm, storage company, or any other firm or business entity that performs any work in conjunction with damages incident to any loss which the adjuster has been contracted to adjust;

(B) Any direct or indirect participation in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the adjuster or disclosure of any other activities that may be reasonably construed as a conflict of interest, including a financial interest in any salvage, repair, construction, or restoration of any business entity that obtains business in connection with any claims that the public adjuster has a contract or agreement to adjust; and

(C) Any direct or indirect compensation of value in connection with an insured's specific loss other than compensation from the insured for service as a public adjuster.

(b) Public adjuster contracts may not contain a contract term that:

(1) Restricts an insured's right to initiate and maintain direct communications with his or her attorney, the insurer, the insurer's adjuster, the insurer's attorney, or any other person regarding settlement of the insured's claim;

(2) Vests the public adjuster with the right to initiate direct communications with the insured's insurer, the insurer's adjuster, or the insurer's attorney regarding settlement of the insured's claim without specific written authorization from the insured;

(3) Allows the public adjuster's percentage fee to be collected when money is due from an insurance company but not paid or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company rather than as a percentage of each check issued by an insurance company;

(4) Requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster; or

(5) Precludes or restricts an insured from pursuing any civil remedies relating to his or her claim.

(c) All public adjuster contracts shall be construed to contain, by operation of law:

(1) A provision granting the insured a right to rescind the contract within three business days after the date the contract was signed, so long as the rescission is in writing and mailed or delivered to the public adjuster at the address stated in the contract within three business days. For purposes of this subsection, rescission of the contract shall be considered delivered or mailed if it is delivered by electronic transmittal to the e-mail address or facsimile specified in the contract for such communications;

(2) A provision that if the insured exercises the right to rescind the contract, anything of value given by the insured under the contract will be returned to the insured within 15 business days following the receipt by the public adjuster of the cancellation notice; and

(3) A provision requiring that, prior to initiating any contact with the insured's insurer, the insurer's adjuster, or the insurer's attorney regarding settlement of the insured's claim, a public adjuster must provide the insurer a notification letter signed by the insured confirming that the insured has authorized the public adjuster to communicate directly with the insurer, the insurer's adjuster, or the insurer's attorney on behalf of the insured.

(d) All public adjuster contracts shall be executed in duplicate to provide an original contract to the public adjuster and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the Commissioner of Insurance. (Code 1981, § 33-23-43.1, enacted by Ga. L. 2014, p. 181, § 5/HB 610; Ga. L. 2015, p. 5, § 33/HB 90.)

Effective date. — This Code section became effective July 1, 2014.

The 2015 amendment, effective March 13, 2015, part of an Act to revise, modernize, and correct the Code, substituted "Public adjusters" for "Requirements for public adjusters" at the beginning of the introductory language of subsection (a).

33-23-43.2. Standard of conduct for public adjusters.

(a) A public adjuster is obligated, under his or her license, to serve with objectivity and complete loyalty to the interest of his or her client alone and to render to the insured such information, counsel, and service within the public adjuster's knowledge, understanding, and opinion that will best serve the insured's insurance claim needs and interest.

(b) A public adjuster shall faithfully observe all of the terms and provisions of the public adjuster contract as prescribed in Code Section 33-23-43.1. (Code 1981, § 33-23-43.2, enacted by Ga. L. 2014, p. 181, § 5/HB 610.)

Effective date. — This Code section became effective July 1, 2014.

ARTICLE 2

LICENSING OF ADMINISTRATORS

33-23-100. Definitions; exemptions; applicability of Code Sections 33-24-59.5 and 33-24-59.14.

JUDICIAL DECISIONS

Preemption. — Because self-funded plans would have different timeliness obligations in different states if amended state prompt-pay legislation went into effect, ERISA preempted the challenged provisions as relating to benefit plans, regardless of whether risk pooling was affected for saving clause purposes; ERISA's deemer clause applied. America's Health Ins. Plans v. Hudgens, 742 F.3d 1319 (11th Cir. 2014).

ARTICLE 3

INSURANCE NAVIGATORS

Effective date. — This article became effective October 1, 2013.

Editor's notes. — Ga. L. 2013, p. 780, § 2/HB 198, not codified by the General Assembly, provides that this article: "shall become applicable only upon the notification by the federal Department of Health and Human Services or other responsible federal agency or official to the Governor, the Commissioner of Insurance, or other responsible agency or official of the State of Georgia that a health insurance exchange has been created or approved to operate within the State of Georgia pursuant to the provisions of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those acts, or upon the initiation of operation of any such exchange within the State of Georgia." Notification was received on October 1, 2013.

CHAPTER 24

INSURANCE GENERALLY

Article 1

General Provisions

ARTICLE 1

GENERAL PROVISIONS

33-24-1. Definitions.

As used in this chapter, the term:

(1) "Policy" means the written contract of or written agreement for or effecting insurance. The term includes all clauses, riders, endorsements, and papers attached or issued and delivered for attachment to the contract or agreement and made a part of the contract or agreement.

(2) "Premium" means the consideration for insurance, by whatever name called. Any assessment or any membership, policy, survey, inspection, service, or similar fee or charge in consideration for an insurance contract is deemed part of the premium. The term "pre-

mium" shall not include any amount deposited and held for the account of the insured which is returnable upon cancellation of the insurance contract and upon which no commission has been paid.

(3) "Uniform Electronic Transactions Act" means Chapter 12 of Title 10. (Code 1933, §§ 56-2402, 56-2403, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1995, p. 1011, § 3; Ga. L. 2014, p. 829, § 3/HB 645.)

The 2014 amendment, effective July 1, 2014, added paragraph (3).

33-24-7. Statements and descriptions in applications or in negotiations deemed representations and not warranties; effect of misrepresentations upon recovery under policies.

Law reviews. — For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014).

JUDICIAL DECISIONS

ANALYSIS

GENERAL CONSIDERATION

General Consideration

Reasonable explanations for contradictory testimony. — In a case in which an insured appealed from a trial court's order granting summary judgment to an insurer on the insured's lawsuit to recover damages in connection with the loss of the insured's home and the home's contents due to a fire, the appellate court directed the trial court on remand to determine whether the insured presented reasonable explanations for the insured's contradictory testimony. Sikes v. Great Lakes Reinsurance (UK) PLC, 321 Ga. App. 136, 741 S.E.2d 263 (2013).

33-24-12. Noncomplying conditions or provisions; cancellation of contracts covering uninsurable subjects.

JUDICIAL DECISIONS

No genuine issue of material fact as to uninsured motorist coverage. — Trial court erred by granting summary judgment to the insurer because the undisputed evidence did not show that the insured made an affirmative choice for less uninsured/underinsured coverage than the statutory default amount set forth in O.C.G.A. § 33-7-11(a)(1)(B); thus, the statutory default amount of coverage applied to the policy, and the trial court erred in construing the policy to provide a lesser amount of coverage. McGraw v. IDS Prop. & Cas. Ins. Co., 323 Ga. App. 408, 744 S.E.2d 891 (2013).

33-24-14. Delivery of policies; applicability of Uniform Electronic Transactions Act; additional mailings.

(a)(1) Subject to the insurer's requirement as to payment of premiums, every policy shall be mailed or delivered to the insured or to the person entitled to the policy within a reasonable period of time after its issuance except where a condition required by the insurer has not been met by the insured.

(2) A policy required to be delivered under this subsection may be delivered by electronic transmittal in accordance with Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," or by electronic posting if that policy is posted electronically, provided that:

(A) The insured has agreed to accept delivery by electronic posting;

(B) The insurer makes the policy accessible as long as the policy is in force;

(C) After the expiration of the policy, the insurer archives its expired policies for a period of five years and makes them available upon request;

(D) The insurer provides the following information in or simultaneously with each declarations page provided at the time of issuance of the initial policy and any renewals of that policy:

(i) A description of the exact policy and endorsement forms purchased by the insured;

(ii) A method by which the insured may obtain, upon request and without charge, a paper copy of such insured's policy; and

(iii) The Internet address where the insured's policy and endorsement are posted; and

(E) The insurer provides notice, in the manner in which the insurer customarily communicates with the insured, of any changes to the forms or endorsements, the insured's right to obtain, upon request and without charge, a paper copy of such forms or endorsements, and the Internet address where such forms or endorsements are posted.

(b) In the event the original policy is delivered or is required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle or aircraft, in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to the vehicle or aircraft is insured, a duplicate of the policy setting forth the name and address of the insurer, the insurance classification of the vehicle or aircraft, the type of coverage, the limits of liability, the premiums for the respective

coverages, and the duration of the policy or memorandum of the policy containing the same information shall be delivered by the vendor, mortgagee, or pledgee to each vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a statement of such fact shall be printed, written, or stamped conspicuously on the face of the duplicate policy or memorandum.

(c) The provisions of Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," apply to this title, and nothing in this Code section shall be construed to limit its applicability.

(d) In addition to any mailing which may be legally accomplished pursuant to Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," any other required mailing may be performed electronically if the following conditions are met:

(1) The Code section which requires a mailing specifically notes that mailing may be accomplished pursuant to this subsection;

(2) The insured agrees to receive mailings electronically by signing a statement which reads:

"I AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY. SUCH ELECTRONIC MAILING OR COMMUNICATIONS MAY EVEN INCLUDE CANCELLATION OR NONRENEWAL NOTICES";

provided, however, that the Commissioner may approve the use of substantially similar language;

(3) If the statement in paragraph (2) of this subsection is physically signed by the insured, then the statement must be in a separate document and written in all capital letters in at least 12 point font, or on a substantially similar form approved by the Commissioner. If the statement is signed electronically, then it must be signed according to a procedure which has been approved by the Commissioner; provided, however, that the Commissioner shall approve a procedure for obtaining a signature only if that procedure is designed to ensure that the statement is not presented in a misleading or confusing manner;

(4) If the insurer becomes aware that the insured's electronic mail address at which such party has consented to receive notices or documents is no longer valid, the insurer shall send the notice or document as required by other applicable law;

(5) The insurer must retain a record pursuant to Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," of the mailing,

including proof of the date of mailing and the address to which the mailing was sent. Such record must be retrievable for a period of five years after the date of such mailing and, if requested, must be transmitted to the Commissioner in a reasonable time;

(6) The insured may withdraw his or her consent to receive mailings electronically;

(7) All conditions have been met under Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," so that the mailing could be accomplished electronically, unless the law requiring the mailing imposes a specific type of delivery method;

(8) All conditions have been met under the federal Electronic Signatures in Global and National Commerce Act, 15 U.S.C. Section 7001, et seq. This Code section shall not modify, limit, or supersede Section 101(c) of such Act or authorize electronic delivery of any of the notices described in Section 103(b) of such Act; and

(9) No insurance company shall cancel, refuse to issue, or refuse to renew any policy because the applicant or insured refuses to agree to receive mailings electronically pursuant to this subsection. (Code 1933, § 56-2421, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2014, p. 829, § 4/HB 645.)

The 2014 amendment, effective July 1, 2014, designated the existing provisions of subsection (a) as paragraph (a)(1), and added paragraph (a)(2); and added subsections (c) and (d).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2014, "apply" was substituted for "applies" in subsection (c).

Law reviews. — For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014).

33-24-16. Construction of policies.

JUDICIAL DECISIONS

ANALYSIS

CONSTRUCTION OF WORDS OR PHRASES

Construction of Words or Phrases

Bad faith not found. — Trial court erred by denying a title company's motion for summary judgment on a lender's claim for coverage under the title insurance policy and for bad faith damages because the policy stated that the title company was liable for the lesser amount of the difference between the value of the insured estate and the value of the insured estate subject to the defect insured against, thus, since the lender received more in the foreclosure sale than the value, the title company was liable for zero. Doss & Assocs. v. First Am. Title Ins. Co., 2013 Ga. App. LEXIS 968 (Nov. 21, 2013).

33-24-21.1. Group accident and sickness contracts; conversion privilege and continuation right provisions; impact of federal legislation.

(a) As used in this Code section, the term:

(1) "Assistance eligible individual" shall have the same meaning as provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act of 2009, as amended.

(2) "Creditable coverage" under another health benefit plan means medical expense coverage with no greater than a 90 day gap in coverage under any of the following:

(A) Medicare or Medicaid;

(B) An employer based accident and sickness insurance or health benefit arrangement;

(C) An individual accident and sickness insurance policy, including coverage issued by a health maintenance organization, nonprofit hospital or nonprofit medical service corporation, health care corporation, or fraternal benefit society;

(D) A spouse's benefits or coverage under medicare or Medicaid or an employer based health insurance or health benefit arrangement;

(E) A conversion policy;

(F) A franchise policy issued on an individual basis to a member of a true association as defined in subsection (b) of Code Section 33-30-1;

(G) A health plan formed pursuant to 10 U.S.C. Chapter 55;

(H) A health plan provided through the Indian Health Service or a tribal organization program or both;

(I) A state health benefits risk pool;

(J) A health plan formed pursuant to 5 U.S.C. Chapter 89;

(K) A public health plan; or

(L) A Peace Corps Act health benefit plan.

(3) "Eligible dependent" means a person who is entitled to medical benefits coverage under a group contract or group plan by reason of such person's dependency on or relationship to a group member.

(4) "Group contract or group plan" is synonymous with the term "contract or plan" and means:

(A) A group contract of the type issued by a nonprofit medical service corporation established under Chapter 18 of this title;

(B) A group contract of the type issued by a nonprofit hospital service corporation established under Chapter 19 of this title;

(C) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(D) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(E) A group accident and sickness insurance policy or contract, as defined in Chapter 30 of this title.

(5) "Group member" means a person who has been a member of the group for at least six months and who is entitled to medical benefits coverage under a group contract or group plan and who is an insured, certificate holder, or subscriber under the contract or plan.

(6) "Insurer" means an insurance company, health care corporation, nonprofit hospital service corporation, medical service nonprofit corporation, health care plan, or health maintenance organization.

(7) "Qualifying eligible individual" means:

(A) A Georgia domiciliary, for whom, as of the date on which the individual seeks coverage under this Code section, the aggregate of the periods of creditable coverage is 18 months or more; and

(B) Who is not eligible for coverage under any of the following:

(i) A group health plan, including continuation rights under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA);

(ii) Part A or Part B of Title XVIII of the federal Social Security Act; or

(iii) The state plan under Title XIX of the federal Social Security Act or any successor program.

(a.1) Any group member or qualifying eligible individual who is an assistance eligible individual as provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, during the period permitted under such act whose coverage has been terminated and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits that it replaces, for at least six months immediately prior to such termination, shall be entitled to have his or her coverage and the coverage of his or her eligible dependents continued under the contract or plan in accordance with paragraph (2) of subsection (c) of

this Code section. Such coverage shall continue for the fractional policy month remaining, if any, at termination plus up to the maximum number of additional policy months specified in paragraph (2) of subsection (c) of this Code section upon payment of the premium to the insurer by cash, certified check, or money order, at the same rate for active group members set forth in the contract or plan, on a monthly basis in advance as such premium becomes due during this coverage period. An assistance eligible individual who is in a transition period as defined in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, shall be treated for purposes of any continuation of coverage provision as having timely paid such premium if such individual was covered under the continuation of coverage to which such premium relates for the period immediately preceding such transition period, if such individual remains eligible for such continuation of coverage, and if such individual pays the amount of such premium not later than 30 days after the date of provision of notice regarding eligibility for extended continuation of coverage. For the period that the assistance eligible individual is eligible for the premium reduction assistance as provided in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, such premium payment shall be calculated as 35 percent of the rate for active group members including any portion of the premium paid by a former employer or other person if such employer or other person no longer contributes premium payments for this coverage.

(a.2) The rights and benefits under this Code section attributable to Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, shall expire when that act expires. Any extension of such benefits shall require an Act of the Georgia General Assembly. Under no circumstances shall the extended benefits for assistance eligible individuals become the responsibility of the State of Georgia or any insurer after the expiration of the premium subsidy made available to individuals pursuant to Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended.

(b) Each group contract or group plan delivered or issued for delivery in this state, other than a group accident and sickness insurance policy, contract, or plan issued in connection with an extension of credit, which provides hospital, surgical, or major medical coverage, or any combination of these coverages, on an expense incurred or service basis, excluding contracts and plans which provide benefits for specific diseases or accidental injuries only, shall provide that members and qualifying eligible individuals whose insurance under the group contract or plan would otherwise terminate shall be entitled to continue their hospital, surgical, and major medical insurance coverage under that group contract or plan for themselves and their eligible dependents.

(c)(1) Any group member or qualifying eligible individual whose coverage has been terminated and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to such termination, shall be entitled to have his or her coverage and the coverage of his or her eligible dependents continued under the contract or plan. Such coverage must continue for the fractional policy month remaining, if any, at termination plus three additional policy months, upon payment of the premium by cash, certified check, or money order, at the option of the employer, to the policyholder or employer, at the same rate for active group members set forth in the contract or plan, on a monthly basis in advance as such premium becomes due during this coverage period. Such premium payment must include any portion of the premium paid by a former employer or other person if such employer or other person no longer contributes premium payments for this coverage. At the end of such period, the group member shall have the same conversion rights that were available on the date of termination of coverage in accordance with the conversion privileges contained in the group contract or group plan.

(2) Any group member or qualifying eligible individual who is an assistance eligible individual has a right to elect continuation of his or her coverage and the coverage of his or her dependents at any time between May 5, 2009, and 60 days after receiving notice from the employer's insurer of the right to participate in state continuation benefits under this Code section in accordance with Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, if:

(A) The individual was involuntarily terminated from employment or otherwise experienced a loss of coverage due to qualifying events specified in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended;

(B) The individual was eligible for state continuation under this chapter at the time of termination;

(C) The individual continues to be eligible for state continuation benefits under this chapter, provided that the total period of continuous eligibility shall not exceed the number of policy months equal to the maximum premium reduction period specified in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, as measured from the month of the qualifying event making the individual an assistance eligible individual; and

(D) The individual or the employer of the individual contacts the insurer and informs the insurer that the individual wants to take

advantage of state continuation coverage under the provisions of Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended.

(3) In addition to the group policy under which the group member was insured, the group member and any qualifying eligible individual shall, to the extent that such plan is currently offered under the group plans offered by the company, also be offered the option of continuation coverage through a high deductible health plan, or its actuarial equivalent, that is eligible for use with a health savings account under the applicable provisions of Section 223 of the Internal Revenue Code. Such high deductible health plans shall have premiums consistent with the underlying group plan of coverage rated relative to the standard or manual rates for the benefits provided.

(d)(1) A group member shall not be entitled to have coverage continued if: (A) termination of coverage occurred because the employment of the group member was terminated for cause; (B) termination of coverage occurred because the group member failed to pay any required contribution; or (C) any discontinued group coverage is immediately replaced by similar group coverage including coverage under a health benefits plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. Further, a group member shall not be entitled to have coverage continued if the group contract or group plan was terminated in its entirety or was terminated with respect to a class to which the group member belonged. This subsection shall not affect conversion rights available to a qualifying eligible individual under any contract or plan.

(2) A qualifying eligible individual shall not be entitled to have coverage continued if the most recent creditable coverage within the coverage period was terminated based on one of the following factors: (A) failure of the qualifying eligible individual to pay premiums or contributions in accordance with the terms of the health insurance coverage or failure of the issuer to receive timely premium payments; (B) the qualifying eligible individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage; or (C) any discontinued group coverage is immediately replaced by similar group coverage including coverage under a health benefits plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. This subsection shall not affect conversion rights available to a group member under any contract or plan.

(e) If the group contract or group plan terminates while any group member or qualifying eligible individual is covered or whose coverage is being continued, the group administrator, as prescribed by the insurer,

must notify each such group member or qualifying eligible individual that he or she must exercise his or her conversion rights within:

(1) Thirty days of such notice for group members who are not qualifying eligible individuals; or

(2) Sixty-three days of such notice for qualifying eligible individuals.

(f) Every group contract or group plan, other than a group accident and sickness insurance policy, contract, or plan issued in connection with an extension of credit, which provides hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred or service basis, excluding policies which provide benefits for specific diseases or for accidental injuries only, shall contain a conversion privilege provision.

(g) Eligibility for the converted policies or contracts shall be as follows:

(1) Any qualifying eligible individual whose insurance and its corresponding eligibility under the group policy, including any continuation available, elected, and exhausted under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than fraud or failure of the qualifying eligible individual to pay a required premium contribution to the employer or, if so required, to the insurer directly and who has at least 18 months of creditable coverage immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group based coverage covering such qualifying eligible individual and any eligible dependents who were covered under the qualifying eligible individual's coverage under the group contract or group plan. Such conversion coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage or the date on which continuation or COBRA coverage ended, whichever is later. The insurer must offer qualifying eligible individuals at least two distinct conversion options from which to choose. One such choice of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in this state or comparable to a standard option of coverage available under the group or individual health insurance laws of this state. The other choice may be more limited in nature but must also qualify as creditable coverage. Each coverage shall be filed, together with applicable rates, for approval by the Commissioner. Such choices shall be known as the "Enhanced Conversion Options";

(2) Premiums for the enhanced conversion options for all qualifying eligible individuals shall be determined in accordance with the following provisions:

(A) Solely for purposes of this subsection, the claims experience produced by all groups covered under comprehensive major medical or hospitalization accident and sickness insurance for each insurer shall be fully pooled to determine the group pool rate. Except to the extent that the claims experience of an individual group affects the overall experience of the group pool, the claims experience produced by any individual group of each insurer shall not be used in any manner for enhanced conversion policy rating purposes;

(B) Each insurer's group pool shall consist of each insurer's total claims experience produced by all groups in this state, regardless of the marketing mechanism or distribution system utilized in the sale of the group insurance from which the qualifying eligible individual is converting. The pool shall include the experience generated under any medical expense insurance coverage offered under separate group contracts and contracts issued to trusts, multiple employer trusts, or association groups or trusts, including trusts or arrangements providing group or group-type coverage issued to a trust or association or to any other group policyholder where such group or group-type contract provides coverage, primarily or incidentally, through contracts issued or issued for delivery in this state or provided by solicitation and sale to Georgia residents through an out-of-state multiple employer trust or arrangement; and any other group-type coverage which is determined to be a group shall also be included in the pool for enhanced conversion policy rating purposes; and

(C) Any other factors deemed relevant by the Commissioner may be considered in determination of each enhanced conversion policy pool rate so long as it does not have the effect of lessening the risk-spreading characteristic of the pooling requirement. Duration since issue and tier factors may not be considered in conversion policy rating. Notwithstanding subparagraph (A) of this paragraph, the total premium calculated for all enhanced conversion policies may deviate from the group pool rate by not more than plus or minus 50 percent based upon the experience generated under the pool of enhanced conversion policies so long as rates do not deviate for similarly situated individuals covered through the pool of enhanced conversion policies;

(3) Any group member who is not a qualifying eligible individual and whose insurance under the group policy has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than eligibility for medicare (reaching a limiting age for coverage under the group policy) or failure of the group member to pay a required premium contribution, and who has been continuously

covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group coverage covering such group member and any eligible dependents who were covered under the group member's coverage under the group contract or group plan. Such conversion coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage or the date on which continuation or COBRA coverage ended, whichever is later. The premium of the basic converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and classification of risks of each person to be covered under that policy and to the type and amount of coverage provided. This form of conversion coverage shall be known as the "Basic Conversion Option"; and

(4) Nothing in this Code section shall be construed to prevent an insurer from offering additional options to qualifying eligible individuals or group members.

(h) Each group certificate issued to each group member or qualifying eligible individual, in addition to setting forth any conversion rights, shall set forth the continuation right in a separate provision bearing its own caption. The provisions shall clearly set forth a full description of the continuation and conversion rights available, including all requirements, limitations, and exceptions, the premium required, and the time of payment of all premiums due during the period of continuation or conversion.

(i) This Code section shall not apply to limited benefit insurance policies. For the purposes of this Code section, the term "limited benefit insurance" means accident and sickness insurance designed, advertised, and marketed to supplement major medical insurance. The term limited benefit insurance includes accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and any other accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, and comprehensive major medical insurance coverage.

(j) The Commissioner shall adopt such rules and regulations as he or she deems necessary for the administration of this Code section. Such rules and regulations may prescribe various conversion plans, including minimum conversion standards and minimum benefits, but not requiring benefits in excess of those provided under the group contract or group plan from which conversion is made, scope of coverage, preexisting limitations, optional coverages, reductions, notices to covered persons, and such other requirements as the Commissioner deems necessary for the protection of the citizens of this state.

(k)(1) Except as provided in paragraph (2) of this subsection, this Code section shall apply to all group plans and group contracts delivered or issued for delivery in this state on or after July 1, 2009, and to group plans and group contracts then in effect on the first anniversary date occurring on or after July 1, 2009.

(2) The provisions of paragraphs (1), (2), and (3) of subsection (c) of this Code section shall apply to all group plans and group contracts in effect on September 1, 2008.

(l) As soon as practicable, but no later than June 4, 2009, the Commissioner shall develop and direct insurers to issue notices for assistance eligible individuals regarding availability of expanded eligibility and continuation coverage assistance to be sent to the last known addresses of such assistance eligible individuals.

(m) Nothing in this chapter shall imply that individuals entitled to continuation coverage who are not assistance eligible individuals shall receive benefits beyond the period of coverage provided in paragraph (1) of subsection (c) of this Code section or that assistance eligible individuals are entitled to any continuation benefit period beyond what is provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act of 2009 or extensions to that Act which are enacted on and after May 5, 2009.

(n)(1) Upon the effective date whereupon guaranteed issue coverage is available pursuant to the federal Patient Protection and Affordable Care Act, an insurer shall not be required to offer conversion and enhanced conversion rights and coverage pursuant to this Code section.

(2) Each insurer may terminate, cancel, or nonrenew all existing conversion and enhanced conversion coverage as of the date on which guaranteed issue coverage is available pursuant to the federal Patient Protection and Affordable Care Act, provided that the insurer provides at least 90 days' notice prior to the discontinuance of the coverage to policyholders and to the Commissioner.

(3) An insurer may not terminate, cancel, or nonrenew any policy under this paragraph if, at the end of the 90 day cancellation period, the insured would not have at least 90 days of remaining open enrollment to obtain insurance coverage through an exchange created pursuant to the federal Patient Protection and Affordable Care Act. (Code 1981, § 33-24-21.1, enacted by Ga. L. 1986, p. 688, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1997, p. 1462, § 3; Ga. L. 1998, p. 1064, § 4; Ga. L. 2002, p. 441, § 10; Ga. L. 2009, p. 737, § 1/SB 94; Ga. L. 2010, p. 87, § 1/HB 1268; Ga. L. 2011, p. 752, § 33/HB 142; Ga. L. 2013, p. 873, § 2/HB 389; Ga. L. 2014, p. 866, § 33/SB 340.)

The 2014 amendment, effective April 29, 2014, part of an Act to revise, modernize, and correct the Code, in subsection (n), redesignated the former introductory language as paragraph (n)(1) and redesignated former paragraphs (n)(1) and (n)(2) as present paragraphs (n)(2) and (n)(3), respectively.

33-24-30. Excluding or denying coverage on basis of violation of civil air regulations.

(a) No policy of insurance issued or delivered in this state covering any loss, expense, or liability arising out of the ownership, maintenance, or use of an aircraft shall exclude or deny coverage because the aircraft is operated in violation of civil air regulations pursuant to federal, state, or local laws or ordinances.

(b) This Code section does not prohibit the use of specific exclusions or conditions in any such policy which relates to any of the following:

(1) Certification of an aircraft in a stated category by the Federal Aviation Administration;

(2) Certification of a pilot in a stated category by the Federal Aviation Administration;

(3) Establishing requirements for pilot experience; or

(4) Establishing limitations on the use of the aircraft.

(c) Any policy of insurance containing one, all, or any combination of the specific exclusions or conditions in the categories permitted in subsection (b) of this Code section shall include conspicuous notice advising the insured that the policy contains such exclusions or conditions and provide specific instructions as to what actions the insured shall undertake in order to protect and preserve his or her rights and coverages under the policy. (Code 1933, § 56-2439, enacted by Ga. L. 1968, p. 1414, § 1; Ga. L. 2015, p. 824, § 1/HB 84.)

The 2015 amendment, effective July 1, 2015, added subsection (c). See editor's note for applicability.

Editor's notes. — Ga. L. 2015, p. 824, § 2/HB 84, not codified by the General Assembly, provides: "This Act shall be applicable to policies issued on or renewed after July 1, 2015."

33-24-33. Binders and other contracts for temporary insurance.

JUDICIAL DECISIONS

Question regarding terms of binder. — Trial court erred in granting partial summary judgment to the insured on the insured's breach of contract claim because a question of fact remained regarding whether the insurance coverage on the insured's other properties provided coverage for property losses due to theft and, thus, whether such coverage was available for the subject property, for which only a binder had been issued at the time of the theft. Ga. Farm Bureau Mut. Ins. Co. v. T & G Enters., 324 Ga. App. 445, 751 S.E.2d 99 (2013).

33-24-41.1. Motor vehicle accident claim covered by two or more insurance carriers; limited release.

Law reviews. — For annual survey on insurance, see 65 Mercer L. Rev. 135 (2013).

JUDICIAL DECISIONS

Settlement does not prevent application of underinsured motorist coverage.

Because the insured accepted the limits of liability insurance coverage of the first defendant and executed a limited-liability release, the insured exhausted the liability limits of the first defendant and was entitled to pursue underinsured motorist benefits to the extent the first defendant was underinsured; the insured's settlement with the dismissed defendants precluded the insured's ability to pursue underinsured motorist benefits against those defendants, but it did not preclude the insured from seeking underinsured motorist benefits based on the possibility that the first defendant was underinsured. Wade v. Allstate Fire & Cas. Co., 324 Ga. App. 491, 751 S.E.2d 153 (2013).

Acceptance of settlement offer.

Insurer complied with the terms of an injured driver's settlement offer by submitting a $25,000 check within the offer's deadline, and the trial court erred in denying the insurer's motion to enforce the settlement agreement based on the insurer's inclusion of a general release rather than a limited release with its letter because the insurer's language regarding the release was precatory rather than mandatory. Newton v. Ragland, 325 Ga. App. 371, 750 S.E.2d 768 (2013).

33-24-44. Cancellation of policies generally.

(a) Except as otherwise provided in this chapter, cancellation of a policy which by its terms and conditions may be canceled by the insurer or its agent duly authorized by the insurer to effect such cancellation shall be accomplished as prescribed in this Code section.

(b) Written notice stating the time when the cancellation will be effective, which shall not be less than 30 days from the date of mailing or delivery in person of such notice of cancellation or such other specific longer period as may be provided in the contract or by statute, shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured and of any lienholder, where applicable, and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service. For the purposes of this subsection, notice to the lienholder shall be considered delivered or mailed if, with the lienholder's consent, it is delivered by electronic transmittal or facsimile. Any irregularity in the notice to the lienholder shall not invalidate an otherwise valid cancellation as to the insured.

(c)(1) Any unearned premium which has been paid by the insured shall be refunded to the insured on a pro rata basis as provided in this

Code section. If the return does not accompany notice of cancellation, then such return shall be made on or before the cancellation date either directly to the named insured or to the insured's agent of record. In the event the insurer elects to return such unearned premium to the insured via the insured's agent of record, such agent shall return the unearned premium to the insured either in person or by depositing such return in the mail within ten working days of receipt of the unearned premium, or within ten working days of notification from the insurer of the amount of return of unearned premium due, or on the effective date of cancellation, whichever is later. If the insured has an open account with the agent, such return of unearned premium may be applied to any outstanding balance and any remaining unearned premium shall be returned to the insured either in person or by depositing such return in the mail within ten working days of receipt of the unearned premium, or within ten working days of notification from the insurer of the amount of return of unearned premium due, or on the effective date of cancellation, whichever is later.

(2) Paragraph (1) of this subsection shall not apply if an audit or rate investigation is required or if the premiums are financed by a premium finance company. If an audit or rate investigation is required, then the refund of unearned premium shall be made within 30 days after the conclusion of the audit or rate investigation. If the premiums are financed by a premium finance company, any unearned premiums shall be tendered to the premium finance company within ten working days after cancellation.

(3) Any insurer or agent failing to return any unearned premium as prescribed in paragraphs (1) and (2) of this subsection shall pay to the insured a penalty equal to 25 percent of the amount of the return of the unearned premium and interest equal to 18 percent per annum until such time that proper return has been made, which penalty and interest must be paid at the time the return is made; provided, however, the maximum amount of such penalty and interest shall not exceed 50 percent of the amount of the refund due. Failure to return any unearned premium shall not invalidate a notice of cancellation given in accordance with subsection (b) of this Code section.

(d) When a policy is canceled for failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums for a policy or any installment of premiums due, whether payable directly to the insurer or indirectly to the agent, or when a policy that has been in effect for less than 60 days is canceled for any reason, the notice requirements of this Code section may be satisfied by delivering or mailing written notice to the named insured and any lienholder, where applicable, at least ten days prior to the

effective date of cancellation in lieu of the number of days' notice otherwise required by this Code section. For the purposes of this subsection, notice to the lienholder shall be considered delivered or mailed if, with the lienholder's consent, it is delivered by electronic transmittal or facsimile. Any irregularity in the notice to the lienholder shall not invalidate an otherwise valid cancellation as to the insured.

(d.1) The notice requirements of this Code section shall not apply in any case where a binder or contract of insurance is void ab initio for failure of consideration.

(d.2) If the terms of a policy permit an audit and the insured fails to submit to or allow an audit for the current or most recently expired term, the insurer may, after two documented efforts to notify the policyholder and the policyholder's agent of potential cancellation, send via certified mail or statutory overnight delivery, return receipt requested, written notice to the named insured at least ten days prior to the effective date of cancellation in lieu of the number of days' notice otherwise required by law; provided, however, that no cancellation notice shall be mailed within 20 days of the first documented effort to notify the policyholder of potential cancellation.

(e) Notice to the insured shall not be required by this Code section when a policy is canceled by an insurance premium finance company under a power of attorney contained in an insurance premium finance agreement which has been filed with the insurer in accordance with the provisions of Chapter 22 of this title. However, the insurer shall comply with the provisions of subsection (d) of Code Section 33-22-13 pertaining to notice to a governmental agency, mortgagee, or other third party. Such notice shall be delivered in person or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of such governmental agency, mortgagee, or other third party and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(f) Cancellation by the insured shall be accomplished in accordance with Code Section 33-24-44.1.

(g) Any unearned premium which has been paid by the insured may be refunded to the insured on other than a pro rata basis if:

(1) The cancellation results from failure of the insured to pay, when due, any premium to the insurer or any amount, when due, under a premium finance agreement;

(2) The policy contains language which specifies that a penalty may be charged on unearned premium; and

(3) The method of computing such penalty is filed with the Commissioner in accordance with Chapter 9 of this title. (Code 1933,

§ 56-2430, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1967, p. 653, § 1; Ga. L. 1968, p. 1126, § 1; Ga. L. 1973, p. 499, § 6; Ga. L. 1975, p. 1242, § 1; Ga. L. 1984, p. 1345, § 4; Ga. L. 1987, p. 1466, § 1; Ga. L. 1995, p. 1011, § 4; Ga. L. 1999, p. 834, § 1; Ga. L. 2005, p. 562, § 1/HB 418; Ga. L. 2014, p. 823, § 1/HB 375; Ga. L. 2014, p. 829, § 5/HB 645; Ga. L. 2015, p. 5, § 33/HB 90.)

The 2014 amendments. — The first 2014 amendment, effective July 1, 2014, added subsection (d.2). See editor's note for applicability. The second 2014 amendment, effective July 1, 2014, inserted "as provided in subsection (d) of Code Section 33-24-14" near the middle of the first sentence of subsection (b).

The 2015 amendment, effective March 13, 2015, part of an Act to revise, modernize, and correct the Code, revised punctuation and language in subsection (b); and revised language in subsection (e).

Editor's notes. — Ga. L. 2014, p. 823, § 2/HB 375, not codified by the General Assembly, provides: "This Act shall be applicable to policies issued or renewed on or after July 1, 2014."

JUDICIAL DECISIONS

ANALYSIS

FORM, SUFFICIENCY, AND PROOF OF NOTICE

Form, Sufficiency, and Proof of Notice

Failure to follow statutory requirements.

Insurer's notice of intent to cancel failed to satisfy insurance cancellation notice requirements because the notice never stated unequivocally that the car insurance policy would have been cancelled for non-payment of premiums, the notice did not unequivocally state that premiums were past due, and the notice also suggested that it was a "billing" notice. Southern Pilot Ins. Co. v. CECS, Inc., No. 1:11-CV-03863-AT, 2013 U.S. Dist. LEXIS 187234 (N.D. Ga. Apr. 19, 2013).

Notice sufficient.

Fact that the insurer's Notice of Intent to Cancel contained an option to avoid imminent cancellation by promptly paying the amount due did not render the Notice of Cancellation purportedly sent with the Notice of Intent ineffective. Southern Pilot Ins. Co. v. CECS, Inc., No. 1:11-CV-03863-AT, 2013 U.S. Dist. LEXIS 187233 (N.D. Ga. Jan. 25, 2013).

33-24-44.1. Procedure for cancellation by insured and notice.

(a) An insured may request cancellation of an existing insurance policy by returning the original policy to the insurer or by making a written request for cancellation of an insurance policy to the insurer or its duly authorized agent stating a future date on which the policy is to be canceled. Such cancellation shall be accomplished in the following manner:

(1) If only the interest of the insured is affected, the policy shall be canceled on the later of the date the returned policy or written request is received by the insurer or its duly authorized agent or the date specified in the written request; provided, however, that upon receipt of a written request for cancellation from an insured, an

insurer may waive the future date requirement by confirming the date and time of cancellation in writing to the insured;

(2) If by statute, regulation, or contract the insurance policy may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party, the insurer shall mail or deliver such notice stating the date cancellation shall become effective, but such date shall not be less than ten days from the date of mailing or delivery of the notice.

(b) Notices required by this Code section shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the named insured, governmental agency, mortgagee, or other third party, where applicable, and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(c) Where any notice is mailed or delivered in accordance with this Code section, the effective date of cancellation of the policy shall be the last effective date of any such notice.

(d) Notwithstanding the failure of the insurer to comply with the provisions of this Code section, cancellation shall be effective on the effective date of any replacement policy providing the same or similar coverage, which date shall not be prior to the date provided in subsection (a) of this Code section.

(e) Except as provided in Chapter 22 of this title, an insurance policy which by its terms may be canceled by the insured shall be canceled in accordance with this Code section. (Code 1981, § 33-24-44.1, enacted by Ga. L. 1987, p. 1466, § 2; Ga. L. 1994, p. 344, § 1; Ga. L. 2014, p. 829, § 6/HB 645; Ga. L. 2015, p. 5, § 33/HB 90.)

The 2014 amendment, effective July 1, 2014, inserted "as provided in subsection (d) of Code Section 33-24-14" near the beginning of subsection (b).

The 2015 amendment, effective March 13, 2015, part of an Act to revise, modernize, and correct the Code, revised punctuation in subsection (b).

33-24-45. Cancellation or nonrenewal of automobile or motorcycle policies; procedure for review by Commissioner.

(a) This Code section shall apply only to those portions of an automobile policy or a motorcycle policy which relate to bodily injury and property damage liability, personal injury protection, medical payments, physical damage, and uninsured motorists' coverage.

(b) As used in this Code section, the term:

(1) "Policy" means a policy insuring a natural person as named insured or one or more related individuals resident of the same household and which provides bodily injury coverage and property damage liability coverage, personal injury protection, physical damage coverage, medical payments coverage, or uninsured motorists' protection coverage or any combination of coverages and under which the insured vehicles designated in the policy are of the following types only:

(A) Any motor vehicle of the private passenger, station wagon, or jeep type or a motorcycle that is not used as a public or livery conveyance for passengers nor rented to others; or

(B) Any other four-wheel motor vehicle with a load capacity of 1,500 pounds or less which is not used in the occupation or professional business of the insured; provided, however, that this Code section shall not apply to policies of automobile liability insurance issued under the Georgia Automobile Insurance Plan nor to any policy insuring an automobile which is one of more than four insured under a single policy nor to any policy covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

(2) "Renewal" means issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer and providing no less than the coverage contained in the superseded policy or issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term or the extension of the term of a policy beyond its policy period or term pursuant to a provision for extending the policy by payment of a continuation premium; provided, however, that any policy with a policy period or term of less than six months shall, for the purpose of this Code section, be considered to have successive policy periods ending each six months following its original date of issue and, regardless of its wording, any interim termination by its terms or by refusal to accept premium shall be a cancellation subject to this Code section, except in case of termination under any of the circumstances specified in subsection (f) of this Code section; provided, further, that, for purposes of this Code section, any policy written for a term longer than one year or any policy with no fixed expiration date shall be considered as if written for successive policy periods or terms of one year and any termination by an insurer effective on an anniversary date of the policy shall be deemed a refusal to renew.

(c) No notice of cancellation of a policy issued for delivery in this state shall be mailed or delivered by an insurer or its agent duly authorized to effect such cancellation, except for one or more of the following reasons:

(1) The named insured failed to discharge when due any of his obligations in connection with the payment of premiums on such policy or any installment of premiums or the renewal of premiums, whether payable directly to the insurer or indirectly to the agent. Notwithstanding the provisions of subsection (d) of Code Section 33-24-44, such notice of cancellation issued to an insured, who is paying on a monthly basis, may be included with the bill issued to the insured, provided that the bill is mailed to the insured at least ten days prior to the due date;

(2) The issuance was obtained through a material misrepresentation;

(3) Any insured violated any of the terms and conditions of the policy;

(4) The named insured failed to disclose fully, if called for in the application, his record for the preceding 36 months of motor vehicle accidents and moving traffic violations;

(5) The named insured failed to disclose in his written application or in response to inquiry by his broker or by the insurer or its agent information necessary for the acceptance or proper rating of the risk;

(6) The named insured made a false or fraudulent claim or knowingly aided or abetted another in the presentation of such a claim;

(7) The named insured or any other operator either resident in the same household or who customarily operates an automobile insured under such policy:

(A) Has, within the 36 months prior to the notice of cancellation, had his driver's license under suspension or revocation;

(B) Is or becomes subject to epilepsy or heart attacks and the individual does not produce a certificate from a physician testifying to his unqualified ability to operate a motor vehicle;

(C) Has an accident record; a conviction record, criminal or traffic; or a physical, mental, or other condition which is such that his operation of an automobile might endanger the public safety;

(D) Has within a three-year period prior to the notice of cancellation been addicted to the use of narcotics or other drugs;

(E) Has been convicted or forfeited bail during the 36 months immediately preceding the notice of cancellation for:

(i) Any felony;

(ii) Criminal negligence resulting in death, homicide, or assault arising out of the operation of a motor vehicle;

(iii) Operating a motor vehicle while in an intoxicated condition or while under the influence of drugs;

(iv) Being intoxicated while in or about an automobile or while having custody of an automobile;

(v) Leaving the scene of an accident without stopping to report;

(vi) Theft or unlawful taking of a motor vehicle; or

(vii) Making false statements in an application for a driver's license; or

(F) Has been convicted of or forfeited bail for three or more violations, within the 36 months immediately preceding the notice of cancellation, of any law, ordinance, or regulation limiting the speed of motor vehicles or any of the provisions of the motor vehicle laws of any state, violation of which constitutes a misdemeanor, whether or not the violations were repetitions of the same offense or different offenses;

(8) The insured automobile:

(A) Is so mechanically defective that its operation might endanger public safety;

(B) Is used in carrying passengers for hire or compensation; provided, however, that the use of an automobile for a car pool shall not be considered use of an automobile for hire or compensation;

(C) Is used in the transportation of flammables or explosives;

(D) Is an authorized emergency vehicle; or

(E) Has changed in shape or condition during the policy period so as to increase substantially the risk.

(d) No notice of cancellation of a policy to which this Code section applies shall be effective unless mailed or delivered as prescribed in Code Section 33-24-44. The insurer shall provide the reason or reasons for such cancellation as required by Chapter 39 of this title.

(e)(1) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the named insured. Such notice stating the time when nonrenewal will be effective, which shall not be less than 30 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last

address of record of the insured and of the lienholder, where applicable, and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(2) The insurer shall specify in writing the reason or reasons for such nonrenewal as required by Chapter 39 of this title.

(3) No notice refusing the renewal of a policy issued for delivery in this state shall be mailed or delivered by an insurer or its agent duly authorized to effect such notice of nonrenewal for the following reasons:

(A) Lack of, lack of potential for, or failure to agree to a writing of supporting insurance business;

(B) A change in the insurer's eligibility rules or underwriting rules, provided that this subparagraph shall not apply to a change in such rules if the change applies uniformly within a specific class or territory and such change has been approved by the Commissioner under subparagraph (B) of paragraph (4) of this subsection;

(C) With respect to any driver or with respect to any automobile or its replacement, except when the replacement is such that together with other relevant underwriting or eligibility rules it would not have been insured as an original policy risk of the insurer, for two or fewer of the following within the preceding 36 month period:

(i) Accidents involving two or more motor vehicles in which the driver of the insured automobile under this subparagraph was not at fault;

(ii) Uninsured or underinsured motorist coverage claims;

(iii) Comprehensive coverage claims; and

(iv) Towing or road service coverage claims;

(D) Age, sex, location of residence address within the state, race, creed, national origin, ancestry, or marital status;

(E) Lawful occupation, provided that the insured automobile is not used in such occupation and provided, further, that such automobile would have been insured as an original policy risk of the insurer when such occupation is considered together with other relevant underwriting or eligibility rules of the insurer;

(F) Military service, provided that the named insured has no change of legal residence from this state;

(G) Number of years of driving experience of a named insured or of any other operator who is either a resident in the same

household or customarily an operator of an automobile insured under such policy;

(H) Accidents or violations which occurred more than 36 months prior to the expiration date or anniversary date of the policy or solely for claims paid or payable pursuant to the policy during the preceding 36 month period which did not aggregate in an amount in excess of $750.00;

(I) One claim against the policy based on fault if such coverage has been in effect continuously for at least 36 preceding months;

(J) Notwithstanding subparagraph (I) of this paragraph, two claims against the policy based on fault if such coverage has been in effect continuously for at least 72 preceding months; and

(K) Factors not relating to the claims record, driving record, or driving ability of the named insured or of any other operator who is either a resident in the same household or customarily an operator of an automobile insured under such policy.

(4)(A) Notwithstanding paragraph (3) of this subsection, any reason set forth in subsection (c) of this Code section, relating to cancellation, shall also constitute a reason for nonrenewal.

(B) If the insurer demonstrates to the satisfaction of the Commissioner that renewal would violate the provisions of this title or would be hazardous to its policyholders or the public, subparagraph (B) or (K) of paragraph (3) shall not apply.

(5)(A) If the insurer complies with paragraph (1) of this subsection, no claim or action may be maintained with respect to a policy which is not renewed unless the named insured files a written notice with the insurer before the time at which nonrenewal becomes effective. The notice shall specify the manner in which the failure to renew is alleged to be unlawful under this subsection. In any subsequent action asserting a violation of this subsection, no violation of this subsection may be alleged other than the specific allegations contained in the notice filed by the named insured.

(B) In addition to other requirements, a notice of nonrenewal shall contain the provisions of subparagraph (A) of this paragraph, in substantially the form which follows:

"NOTICE

Code Section 33-24-45 of the Official Code of Georgia Annotated provides that this insurer must, upon request, furnish you with the reasons for the failure to renew this policy. If you wish to assert that the nonrenewal is unlawful, you must file a written notice with this insurer before the time at which the nonrenewal

becomes effective. The notice must specify the manner in which the failure to renew is alleged to be unlawful.

If you do not file the written notice, you may not later assert a claim or action against this insurer based upon an unlawful nonrenewal."

(6)(A) Notwithstanding paragraph (3) of this subsection, the termination of an agency relationship shall be valid as a reason for a failure to renew a policy. In such case, if the named insured wishes to retain the policy with the particular insurer, the insured shall locate another agent of the insurer and apply for the policy with another agent of the insurer before the time at which the nonrenewal becomes effective. Upon receipt of the application, the insurer shall treat the application as a renewal and not as an original writing. Nothing in this subparagraph shall abridge or supersede contractual rights of the terminated agency or the insurer, provided that these contractual rights do not adversely affect the privilege of the named insured to apply for renewal through another agent of the insurer.

(B) A notice of nonrenewal based upon the termination of an agency relationship shall contain the provisions of subparagraph (A) of this paragraph, in substantially the form which follows:

"NOTICE

Your policy has not been renewed because your present agent no longer represents this insurer. You have the option of procuring coverage through your present agent or retaining this policy by applying through another agent of this insurer. Code Section 33-24-45 of the Official Code of Georgia Annotated provides that if you will locate another agent of this insurer and apply for this policy before the time at which the nonrenewal becomes effective, this insurer will treat the application as a renewal and not as an application for a new policy."

(f) Subsection (e) of this Code section shall not apply in case of:

(1) Nonpayment of premium for the expiring policy;

(2) Failure of the insured to pay the premium as required by the insurer for renewal; or

(3) The insurer having manifested its willingness to renew by delivering a renewal policy, renewal certificate, or other evidence of renewal to the named insured or his representative or by offering to issue a renewal policy, certificate, or other evidence of renewal or having manifested such intention by any other means.

(g) Notwithstanding the failure of an insurer to comply with this Code section, termination of any coverage under the policy either by

cancellation or nonrenewal shall be effective on the effective date of any other policy providing similar coverage on the same motor vehicle or any replacement of coverage.

(h) Renewal or continuation of a policy shall not constitute a waiver or estoppel with respect to ground for cancellation which existed before the effective date of the renewal or continuance.

(i) When a policy is canceled other than for nonpayment of premium or in the event of a refusal to renew or continue a policy, the insurer shall notify the named insured of his possible eligibility for insurance through the Georgia Automobile Insurance Plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew or not to continue the policy and shall state that such notice of availability of the Georgia Automobile Insurance Plan is given pursuant to this Code section.

(j) There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his employees or against any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal for any statement made by any of them in any written notice of cancellation or nonrenewal or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal or providing information pertaining to the reasons for cancellation or nonrenewal or for statements made or evidence submitted at any formal or informal hearing conducted in connection with the reasons for cancellation or nonrenewal of the insured's policy.

(k) This Code section shall not apply to any policy which has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal of a policy. Such policies shall be canceled in accordance with Code Section 33-24-44.

(l) Return of unearned premium, if any, due to cancellations as to which this Code section applies shall be processed in accordance with Code Section 33-24-44.

(m) Notice to the insured shall not be required by this Code section when a policy is canceled by an insurance premium finance company under a power of attorney contained in an insurance premium finance agreement if notification of the existence of the premium finance agreement has been given to the insurer in accordance with the provisions of Chapter 22 of this title. However, the insurer shall comply with the provisions of subsection (d) of Code Section 33-22-13 pertaining to notice to a governmental agency, mortgagee, or other third party. Such notice shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United

States mail to be dispatched by at least first-class mail to the last address of record of such governmental agency, mortgagee, or other third party and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(n) Cancellation by the insured shall be accomplished as provided in Code Section 33-24-44.1.

(o) An insured may request a review by the Commissioner if the insured believes that his or her policy has been canceled or nonrenewed in violation of this Code section. Such request must be filed with the Commissioner within 15 days of receipt of a notice of cancellation or nonrenewal. A review of the cancellation or nonrenewal shall be conducted within 30 days of said request. The Commissioner shall notify the insured and the insurer of his or her decision within the 30 day period. During the pendency of such review, the policy shall continue in full force and effect and the Commissioner shall specify by rule or regulation the method of payment of premium due and the disposition of premium refunds, if any. The Commissioner shall either require that the policy be reinstated or renewed or may uphold the nonrenewal or cancellation. In the event the Commissioner determines that an insurer's cancellation or nonrenewal action constitutes an unfair act or practice, the Commissioner may take action as authorized by this title. Following the completion of any review provided by this subsection, an insured may request a hearing pursuant to Code Section 33-2-17, and nothing in this subsection shall be deemed to waive an insured's right to request such a hearing. (Code 1933, § 56-2430.1, enacted by Ga. L. 1968, p. 1126, § 1; Ga. L. 1971, p. 658, §§ 1-5; Ga. L. 1975, p. 1242, §§ 2, 3; Ga. L. 1982, p. 3, § 33; Ga. L. 1984, p. 1345, § 5; Ga. L. 1987, p. 1466, § 3; Ga. L. 1988, p. 677, §§ 1, 2; Ga. L. 1991, p. 1608, §§ 1.8, 1.9, 1.10, 1.11; Ga. L. 1996, p. 705, § 15; Ga. L. 1996, p. 767, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2012, p. 1117, § 6/SB 385; Ga. L. 2014, p. 829, §§ 7, 8/HB 645; Ga. L. 2015, p. 5, § 33/HB 90.)

The 2014 amendment, effective July 1, 2014, inserted "as provided in subsection (d) of Code Section 33-24-14" in the middle of the second sentence of paragraph (e)(1) and near the beginning of the last sentence of subsection (m).

The 2015 amendment, effective March 13, 2015, part of an Act to revise, modernize, and correct the Code, revised punctuation and language in paragraph (e)(1) and subsection (m).

JUDICIAL DECISIONS

Analysis

General Consideration

General Consideration

Cited in McGraw v. IDS Prop. & Cas. Ins. Co., 323 Ga. App. 408, 744 S.E.2d 891 (2013).

33-24-46. Cancellation or nonrenewal of certain property insurance policies.

(a) This Code section shall apply only to policies of insurance against direct loss to residential real property and the contents thereof, as defined and limited in standard fire policies insuring natural persons as the named insured.

(b) As used in this Code section, the term:

(1) "Claim against a policy" means a contact with an insurer by the insured under the policy or an affected third party for the express purpose of seeking payment of proceeds under the terms of the policy in question. A report of loss or a question relating to coverage shall not independently establish a claim against a policy nor be considered as a claim under Article 2 of Chapter 6 of this title.

(2) "Nonrenewal" or "nonrenewed" means a refusal by an insurer or an affiliate of an insurer to renew. Failure of an insured to pay the premium as required of the insured for renewal after the insurer has manifested a willingness to renew by delivering a renewal policy, renewal certificate, or other evidence of renewal to the named insured or his or her representative or has offered to issue a renewal policy, certificate, or other evidence of renewal or has manifested such intention by any other means shall not be construed to be a nonrenewal.

(3) "Policies" means a policy insuring a natural person as named insured against direct loss to residential real property and the contents thereof, as defined and limited in standard fire policies as approved by the Commissioner.

(4) "Renewal" means issuance and delivery by an insurer or an affiliate of such insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer and providing no less than the coverage contained in the superseded policy or issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term or the extension of the term of a policy beyond its policy period or term pursuant to a provision for extending the policy by payment of a continuation premium. Any policy with a policy period or term of less than six months shall, for the purposes of this Code section, be considered to have successive policy periods ending each six months following its original date of issue and, regardless of its wording, any interim

termination by its terms or by refusal to accept premiums shall be a cancellation subject to this Code section. Any policy written for a term longer than one year or any policy with no fixed expiration date shall be considered as if written for successive policy periods or terms of one year and any termination by an insurer effective on an anniversary date of such policy shall be deemed a refusal to renew.

(c)(1) No notice of cancellation of a policy as to which this Code section applies shall be effective unless mailed or delivered as prescribed in Code Section 33-24-44. The insurer shall provide the reason or reasons for such cancellation as required by Chapter 39 of this title.

(2) After coverage under a policy to which this Code section applies has been in effect more than 60 days or after the effective date of a renewal policy to which this Code section applies, a notice of cancellation may be issued only for one or more of the following reasons:

(A) Nonpayment of premium;

(B) Discovery of fraud, concealment of material fact, or material misrepresentation made by or with the knowledge of the insured in obtaining the policy, continuing the policy, or presenting a claim under the policy;

(C) The occurrence of a change in the risk which substantially increases any hazard the policy insures against; or

(D) The insured violates any of the material terms or conditions of the policy.

(d) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the named insured. Such notice stating the time when nonrenewal will be effective, which shall not be less than 30 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured and of the lienholder, where applicable, and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service. The insurer shall provide the reason or reasons for nonrenewal as required by Chapter 39 of this title.

(e) When a policy is canceled other than for nonpayment of premium or in the event of a refusal to renew or continue a policy, the insurer shall notify the named insured of his possible eligibility for insurance through the Georgia Fair Access to Insurance Requirements Plan. The

notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew or not to continue the policy and shall state that such notice availability of the Georgia Fair Access to Insurance Requirements Plan is given pursuant to this Code section. Included in the notice shall be the address by which the Georgia Fair Access to Insurance Requirements Plan might be contacted in order to determine eligibility.

(f) There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his employees or against any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal for any statement made by any of them and in written notice of cancellation or nonrenewal or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal or providing information pertaining thereto or for statements made or evidence submitted at any formal or informal hearing conducted in connection therewith.

(g) Return of unearned premium, if any, due to cancellations as to which this Code section applies shall be processed in accordance with Code Section 33-24-44.

(h) Notice to the insured shall not be required by this Code section when a policy is canceled by an insurance premium finance company under a power of attorney contained in an insurance premium finance agreement if notification of the existence of the premium finance agreement has been given to the insurer in accordance with the provisions of Chapter 22 of this title. However, the insurer shall comply with the provisions of subsection (d) of Code Section 33-22-13 pertaining to notice to a governmental agency, mortgagee, or other third party. Such notice shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of such governmental agency, mortgagee, or other third party and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(i) Cancellation by the insured shall be accomplished as provided in Code Section 33-24-44.1.

(j) No notice refusing the renewal of a policy issued for delivery in this state shall be mailed or delivered by an insurer or its agent duly authorized to effect such notice of nonrenewal for the following reasons:

(1) Lack of, lack of potential for, or failure to agree to a writing of supporting insurance business;

(2) A change in the insurer's eligibility rules or underwriting rules, provided that this paragraph shall not apply to a change in such rules

if the change applies uniformly within a specific class or territory and such change has been approved by the Commissioner under subsection (k) of this Code section; and

(3) Two or fewer claims against the policy within the preceding 36 month period if such claims are not attributable to the negligent or intentional acts of the insured or of persons residing at the insured premises.

(k) If the insurer demonstrates to the satisfaction of the Commissioner that renewal would violate the provisions of this title or would be hazardous to its policyholders or the public, paragraph (2) of subsection (j) shall not apply.

(l)(1) If the insurer complies with subsection (d) of this Code section, no claim or action may be maintained with respect to a policy which is not renewed unless the named insured files a written notice with the insurer before the time at which nonrenewal becomes effective. The notice shall specify the manner in which the failure to renew is alleged to be unlawful under this subsection. In any subsequent action asserting a violation of subsection (c), (j), or (k) of this Code section, no violation may be alleged other than the specific allegations contained in the notice filed by the named insured.

(2) In addition to other requirements, a notice of nonrenewal shall contain the provisions of paragraph (1) of this subsection in substantially the form which follows:

"NOTICE

Code Section 33-24-46 of the Official Code of Georgia Annotated provides that this insurer must, upon request, furnish you with the reasons for the failure to renew this policy. If you wish to assert that the nonrenewal is unlawful, you must file a written notice with this insurer before the time at which the nonrenewal becomes effective. The notice must specify the manner in which the failure to renew is alleged to be unlawful.

If you do not file the written notice, you may not later assert a claim or action against this insurer based upon an unlawful nonrenewal."

(m)(1) Notwithstanding subsection (j) of this Code section, the termination of an agency relationship shall be valid as a reason for a failure to renew a policy. In such case, if the named insured wishes to retain the policy with the particular insurer, the insured shall locate another agent of the insurer and apply for the policy with another agent of the insurer before the time at which the nonrenewal becomes effective. Upon receipt of the application, the insurer shall treat the application as a renewal and not as an original writing. Nothing in

this paragraph shall abridge or supersede contractual rights of the terminated agency or the insurer, provided that these contractual rights do not adversely affect the privilege of the named insured to apply for renewal through another agent of the insurer.

(2) A notice of nonrenewal based upon the termination of an agency relationship shall contain the provisions of paragraph (1) of this subsection, in substantially the form which follows:

"NOTICE

Your policy has not been renewed because your present agent no longer represents this insurer. You have the option of procuring coverage through your present agent or retaining this policy by applying through another agent of this insurer. Code Section 33-24-46 of the Official Code of Georgia Annotated provides that if you will locate another agent of the insurer and apply for this policy before the time at which the nonrenewal becomes effective, this insurer will treat the application as a renewal and not as an application for a new policy."

(Code 1933, § 56-2430.3, enacted by Ga. L. 1978, p. 2017, § 1; Ga. L. 1984, p. 1345, § 6; Ga. L. 1987, p. 1466, § 4; Ga. L. 1988, p. 677, §§ 3, 4; Ga. L. 1993, p. 483, § 6; Ga. L. 1995, p. 1011, § 5; Ga. L. 1996, p. 767, § 2; Ga. L. 2004, p. 754, § 2; Ga. L. 2014, p. 829, §§ 9, 10/HB 645; Ga. L. 2015, p. 5, § 33/HB 90.)

The 2014 amendment, effective July 1, 2014, inserted "as provided in subsection (d) of Code Section 33-24-14" in the middle of the first sentence of subsection (d) and near the beginning of the last sentence of subsection (h).

The 2015 amendment, effective March 13, 2015, part of an Act to revise, modernize, and correct the Code, revised punctuation and language in subsections (d) and (h).

33-24-47. Notice required of termination or nonrenewal, increase in premium rates, or change restricting coverage; failure of insurer to comply.

(a) Each insurer licensed to transact business in this state which issues or issues for delivery in this state policies or contracts of insurance insuring risks or residents in this state and insuring against liability for loss of, damage to, or injury to persons or property shall comply with the provisions of this Code section. This Code section shall not apply to personal automobile or personal property and casualty insurance policies. Cancellation of a policy for failure of the named insured to discharge when due any obligations in connection with the payment of premiums or cancellation for any reason of a policy that has been in effect for less than 60 days shall be governed by the provisions of Code Section 33-24-44.

(b) A notice of termination, including a notice of cancellation or nonrenewal, by the insurer, a notice of an increase in premiums, other than an increase in premiums due to a change in risk or exposure, including a change in experience modification or resulting from an audit of auditable coverages, which exceeds 15 percent of the current policy's premium, or a notice of change in any policy provision which limits or restricts coverage shall be delivered to the insured as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail, to be dispatched by at least first-class mail to the last address of record of the insured, at least 45 days prior to the termination date of such policy; provided, however, that a notice of cancellation or nonrenewal of a policy of workers' compensation insurance shall be controlled by the provisions of subsection (f) of this Code section. In those instances where an increase in premium exceeds 15 percent, the notice to the insured shall indicate the dollar amount of the increase. The insurer may obtain a receipt provided by the United States Postal Service as evidence of mailing such notice or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(c) The failure of an insurer to comply with the requirements of subsection (b) of this Code section shall entitle the policyholder to purchase, under the same premiums and policy terms and conditions, an additional 30 day period of insurance coverage beyond the termination date of such policy; provided, however, that the policyholder shall tender the premium amount, computed on a pro rata basis, to the insurer on or before the termination date. No provision of this Code section shall be construed as requiring the insurance coverage under a policy to be extended for more than 30 days from the termination date stated in such policy. An insurer shall not be subject to any other penalty for the failure to comply with the requirements of subsection (b) of this Code section unless the Commissioner finds, after a hearing, that such noncompliance by the insurer has occurred with such frequency as to indicate a general business practice by the insurer of noncompliance with subsection (b) of this Code section. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or the Commissioner's employees or against any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal for any statement made by any of them and in written notice of cancellation or nonrenewal or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal or providing information pertaining thereto or for statements made or evidence submitted at any formal or informal hearing conducted in connection therewith.

(d) This Code section shall not apply to policies canceled in accordance with the provisions of Chapter 22 of this title.

(e) Cancellation by the insured shall be accomplished in accordance with Code Section 33-24-44.1.

(f) A notice of cancellation or nonrenewal of a policy of workers' compensation insurance shall be dispatched to the insured as provided in subsection (d) of Code Section 33-24-14 or by certified mail or statutory overnight delivery, return receipt requested, to the last address of record of the insured at least 75 days prior to the termination date of such policy. The workers' compensation insurer shall retain the receipt of mailing provided by the United States Postal Service as evidence of mailing unless such mailing was accomplished as provided in subsection (d) of Code Section 33-24-14. (Code 1981, § 33-24-47, enacted by Ga. L. 1986, p. 695, § 1; Ga. L. 1987, p. 1466, §§ 5, 6; Ga. L. 1993, p. 1507, § 2; Ga. L. 1996, p. 705, § 16; Ga. L. 2000, p. 1589, § 3; Ga. L. 2014, p. 829, §§ 11, 12/HB 645; Ga. L. 2015, p. 5, § 33/HB 90.)

The 2014 amendment, effective July 1, 2014, inserted "as provided in subsection (d) of Code Section 33-24-14" in the middle of the first sentence of subsections (b) and (f); and added "unless such mailing was accomplished as provided in subsection (d) of Code Section 33-24-14" at the end of the second sentence of subsection (f).

The 2015 amendment, effective March 13, 2015, part of an Act to revise, modernize, and correct the Code, revised punctuation in subsection (b) and substituted "Code Section 33-24-14 or by" for "Code Section 33-24-14 by" in the first sentence of subsection (f).

33-24-47.1. Notice prior to cancellation or nonrenewal of individual or group accident and sickness policy.

(a) This Code section shall apply only to policies, contracts, or certificates of insurance insuring against loss resulting from sickness or from bodily injury or death by accident, or both, or any contract to furnish ambulance service in the future governed by the provisions of Chapters 15, 18, 19, 20, 21, 30, and 42 of this title.

(b) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the group policyholder. Such notice stating the time when nonrenewal will be effective, which shall not be less than 60 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered in person or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the group policyholder and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(c) Notice to the group policyholder shall not be required by this Code section when a group or blanket accident and sickness policy is canceled

by an insurer for nonpayment of any premium at the expiration of the grace period as required by Code Section 33-30-4 or when the group policyholder has given any required written notice of termination to the insurer.

(d) Notice by the insurer to the group members shall be required by this Code section when a group or blanket accident and sickness policy is canceled or not renewed, within 14 days of the expiration of the grace period, by an insurer for nonpayment of any premium as required by Code Section 33-30-4. Such notice of cancellation shall be delivered to each group member affected either in person or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the group member and receiving the receipt provided by the United States Postal Service, or such other evidence of mailing as prescribed or accepted by the United States Postal Service. Such notice shall be accompanied by a statement of the enrollee's continuation or conversion rights under Code Section 33-24-21.1 or 33-24-21.2 or any other applicable Code section. If such group or blanket accident or sickness policy is canceled or not renewed due to intentional nonpayment of premium by the group policyholder, the group policyholder shall have the duty to notify the enrollees of termination of coverage no later than 14 days after the expiration of the grace period provided in Code Section 33-30-4.

(e) A notice of termination of a policy to which subsection (b) of this Code section applies shall be mailed or delivered to the group policyholder and to each employer group or subgroup insured under the policy not less than 60 days prior to the effective date of the termination of the policy. A notice of termination shall be mailed or delivered in the same manner provided in subsection (b) of this Code section for a notice of nonrenewal. (Code 1981, § 33-24-47.1, enacted by Ga. L. 1989, p. 891, § 1; Ga. L. 1991, p. 1358, § 1; Ga. L. 2002, p. 441, § 7; Ga. L. 2015, p. 5, § 33/HB 90.)

The 2015 amendment, effective March 13, 2015, part of an Act to revise, modernize, and correct the Code, revised language in subsection (b).

33-24-51. Purchase of insurance covering injuries resulting from governmental ownership and use of motor vehicles; waiver of governmental immunity; limitation of liabilities.

Law reviews. — For annual survey on local government law, see 65 Mercer L. Rev. 205 (2013).

JUDICIAL DECISIONS

ANALYSIS

General Consideration

Cited in City of Atlanta v. Mitcham, 296 Ga. 576, 769 S.E.2d 320 (2015); Primas v. City of Milledgeville, 296 Ga. 584, 769 S.E.2d 326 (2015).

Waiver of Immunity

School district waived immunity to extent of insurance covering school bus accident. — In a parent's action against a school district for the death of the parent's child as the child tried to board a school bus, although the district had sovereign immunity, the district waived sovereign immunity to the extent of the district's purchase of liability insurance pursuant to O.C.G.A. § 33-24-51(b); the exclusion from the waiver of sovereign immunity for school districts in O.C.G.A. § 36-92-2(a) did not extend to the second sentence of § 33-24-51(b). Tift County Sch. Dist. v. Martinez, 331 Ga. App. 423, 771 S.E.2d 117 (2015).

Limited waiver.

Limited waiver of sovereign immunity set forth in O.C.G.A. § 33-24-51(b) does not implicate the 12-month presentation requirement under O.C.G.A. § 36-11-1. Warnell v. Unified Gov't of Athens-Clarke County, 328 Ga. App. 903, 763 S.E.2d 284 (2014).

33-24-53. Solicitation, release, or sale of automobile accident information prohibited; definitions; exceptions; penalties.

(a) As used in this Code section, the term:

(1) "Capper," "runner," or "steerer" means a person who receives a pecuniary benefit from a practitioner or health care service provider, whether directly or indirectly, to solicit, procure, or attempt to procure a client, patient, or customer at the direction or request of, or in cooperation with, a practitioner or health care service provider whose purpose is to obtain benefits under a contract of insurance or to assert a claim against an insured or an insurer for providing services to the client, patient, or customer. Capper, runner, or steerer shall not include:

(A) Any insurance company or agent or employee thereof who provides referrals or recommendations to its insureds; or

(B) A practitioner or health care service provider who procures clients, patients, or customers through the use of public media or by referrals or recommendations from other practitioners or health care service providers.

(2) "Practitioner" means an attorney, health care professional, owner or partial owner of a health care practice or facility, or any person employed or acting on behalf of any of the individuals in this paragraph.

(3) "Public media" means telephone directories, professional directories, newspapers and other periodicals, radio and television, billboards, and mailed or electronically transmitted written communications that do not involve in-person contact with a specific prospective client, patient, or customer.

(b) Except as provided for in paragraph (5) of subsection (a) of Code Section 50-18-72, it is unlawful for any person in an individual capacity or in a capacity as a law enforcement officer, law enforcement records staff member, wrecker services staff member, emergency staff member, physician, hospital employee, or attorney to solicit, release, or sell any information relating to the parties of a motor vehicle collision for personal financial gain. This subsection shall not apply to mass public media advertisement and solicitation.

(c) It is unlawful for:

(1) Any person in an individual capacity or in a capacity as a public or private employee or any firm, corporation, partnership, or association to act as a capper, runner, or steerer for any practitioner or health care service provider. This paragraph shall not prohibit an attorney or health care provider from making a referral and receiving compensation as is permitted under applicable professional rules of conduct; and

(2) Any practitioner or health care service provider to compensate or give anything of value to a person acting as a capper, runner, or steerer. It is also unlawful for any capper, runner, or steerer to recommend or secure a practitioner's or health care service provider's employment by a client, patient, or customer if such practitioner or health care service provider obtains or intends to obtain benefits under a contract of insurance or asserts a claim against an insured or an insurer for providing services to the client, patient, or customer.

(d) Any natural person convicted of a violation of this Code section shall, on the first offense, be guilty of a misdemeanor and, upon conviction thereof, shall be punished by imprisonment of not less than 30 days and a fine not to exceed $1,000.00. Any natural person convicted of a second or subsequent violation of this Code section shall be guilty of a felony and, upon conviction thereof, shall be punished by imprisonment of not more than ten years and by a fine of not more than $100,000.00 per violation. (Code 1981, § 33-24-53, enacted by Ga. L. 2014, p. 418, § 1/HB 828.)

Effective date. — This Code section became effective July 1, 2014.

Editor's notes. — This Code section formerly pertained to prohibition and penalties for compensation for referrals or recommendations to attorneys and was repealed by Ga. L. 2014, p. 418, § 1/HB 828, effective July 1, 2014. The former Code section was based on Code 1981, § 33-24-53, enacted by Ga. L. 1991, p. 1864, § 2; Ga. L. 2011, p. 583, § 9/HB 137; Ga. L. 2012, p. 775, § 33/HB 942.

OPINIONS OF THE ATTORNEY GENERAL

Updating of crimes and offenses for which Georgia Crime Information Center is authorized to collect and file fingerprints. — Pursuant to authority granted to the Attorney General in O.C.G.A. § 35-3-33(a)(1)(A)(v), any misdemeanor offenses arising under O.C.G.A. §§ 16-11-130.2, 16-11-90(b), 16-8-14.1(a), 16-8-22, and 33-24-53, are designated as ones for which those charged are to be fingerprinted. 2014 Op. Att'y Gen. No. 2014-2.

33-24-56.1. Reimbursement of medical expense or disability benefit providers in personal injury cases; subrogation prohibited; notice.

JUDICIAL DECISIONS

Cited in Woodcraft by MacDonald, Inc. v. Ga. Cas. & Sur. Co., 293 Ga. 9, 743 S.E.2d 373 (2013).

33-24-56.5. Health benefit policy to provide coverage for orally administered chemotherapy for the treatment of cancer; definitions.

(a) As used in this Code section, the term:

(1) "Cost sharing requirements" includes co-payments, coinsurance, deductibles, and any other amounts paid by the covered person for a prescription dispensed by a licensed retail pharmacy.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state on or after January 1, 2015. The term "health benefit policy" does not include the following limited benefit insurance policies: accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, Medicaid, medicare supplement, specified disease, vision, self-insured plans, and nonrenewable individual policies written for a period of less than six months.

(3) "Insurer" means any person, corporation, or other entity authorized to provide health benefit policies under this title.

(b) A health benefit policy that provides coverage for intravenously administered or injected chemotherapy for the treatment of cancer shall provide coverage for orally administered chemotherapy for the treatment of cancer on a basis no less favorable than the intravenously administered or injected chemotherapy regardless of the formulation or benefit category determination by the insurer.

(c) An insurer providing a health benefit policy and any participating entity through which the insurer offers health services shall not:

(1) Vary the terms of any health benefit policy in effect on December 30, 2014, to avoid compliance with this Code section;

(2) Provide any incentive, including, but not limited to, a monetary incentive, or impose treatment limitations to encourage a covered person to accept less than the minimum protections available under this Code section;

(3) Penalize a health care practitioner or reduce or limit the compensation of a health care practitioner for recommending or providing services or care to a covered person as required under this Code section;

(4) Provide any incentive, including, but not limited to, a monetary incentive, to induce a health care practitioner to provide care or services that do not comply with this Code section; or

(5) Change the classification of any intravenously administered or injected chemotherapy treatment or increase the amount of cost sharing applicable to any intravenously administered or injected chemotherapy in effect on January 1, 2015, in order to achieve compliance with this Code section.

(d) An insurer that limits the total amount paid by a covered person through all cost sharing requirements to no more than $200.00 per filled prescription for any orally administered chemotherapy shall be deemed to be in compliance with this Code section. (Code 1981, § 33-24-56.5, enacted by Ga. L. 2014, p. 243, § 2-2/HB 943.)

Effective date. — This Code section became effective January 1, 2015.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2014, "January 1, 2015" was substituted for "effective date of this Code section" in the first sentence of paragraph (a)(2).

Editor's notes. — Ga. L. 2014, p. 243, § 2-2/HB 943, not codified by the General Assembly, provides: "This Act shall be known and may be cited as the 'Cancer Treatment Fairness Act.'"

Law reviews. — For article on the 2014 enactment of this Code section, see 31 Ga. St. U.L. Rev. 113 (2014).

33-24-59.5. Definitions; timely payment of health benefits; notification of failure to pay; penalties; applicability.

Law reviews. — For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014).

33-24-59.10. (For effective date, see note.) Coverage for autism.

(a) As used in this Code section, the term:

(1) "Accident and sickness contract, policy, or benefit plan" shall have the same meaning as found in Code Section 33-24-59.1. Accident

and sickness contract, policy, or benefit plan shall also include without limitation any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45. Accident and sickness contract, policy, or benefit plan shall not include limited benefit insurance policies designed, advertised, and marketed to supplement major medical insurance such as accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and any other type of accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, or major medical insurance.

(2) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(3) "Autism spectrum disorder" means autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(4) "Treatment of autism spectrum disorder" includes the following types of care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder:

(A) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis shall be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

(B) Counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker; and

(C) Therapy services provided by a licensed or certified speech therapist, speech-language pathologist, occupational therapist, physical therapist, or marriage and family therapist.

(b) Accident and sickness contracts, policies, or benefit plans shall provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is six years of age or under in accordance with the following:

(1) The policy or contract shall provide coverage for any assessments, evaluations, or tests by a licensed physician or licensed

psychologist to diagnose whether an individual has an autism spectrum disorder;

(2) The policy or contract shall provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this Code section at least annually;

(3) The policy or contract shall not include any limits on the number of visits;

(4) The policy or contract may limit coverage for applied behavior analysis to $30,000.00 per year. An insurer shall not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph; and

(5) This subsection shall not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy or contract. Coverage for prescription drugs for the treatment of autism spectrum disorders shall be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy or contract.

(c) Except as otherwise provided in this Code section, any policy or contract that provides coverage for services under this Code section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles, and exclusions to the extent that these provisions are not inconsistent with the requirements of this Code section.

(d) This Code section shall not be construed to affect any obligation to provide services to an individual with an autism spectrum disorder under an individualized family service plan, an individualized education plan as required by the federal Individuals with Disabilities Education Act, or an individualized service plan. This Code section also shall not be construed to limit benefits that are otherwise available to an individual under an accident and sickness contract, policy, or benefit plan.

(e)(1) An insurer, corporation, or health maintenance organization, or a governmental entity providing coverage for such treatment pursuant to this Code section, is exempt from providing coverage for behavioral health treatment required under this Code section and not covered by the insurer, corporation, health maintenance organization, or governmental entity providing coverage for such treatment pursuant to this Code section as of December 31, 2016, if:

(A) An actuary, affiliated with the insurer, corporation, or health maintenance organization, who is a member of the American

Academy of Actuaries and meets the American Academy of Actuaries' professional qualification standards for rendering an actuarial opinion related to health insurance rate making, certifies in writing to the Commissioner that:

(i) Based on an analysis to be completed no more frequently than one time per year by each insurer, corporation, or health maintenance organization, or such governmental entity, for the most recent experience period of at least one year's duration, the costs associated with coverage of behavioral health treatment required under this Code section, and not covered as of December 31, 2016, exceeded 1 percent of the premiums charged over the experience period by the insurer, corporation, or health maintenance organization; and

(ii) Those costs solely would lead to an increase in average premiums charged of more than 1 percent for all insurance policies, subscription contracts, or health care plans commencing on inception or the next renewal date, based on the premium rating methodology and practices the insurer, corporation, or health maintenance organization, or such governmental entity, employs; and

(B) The Commissioner approves the certification of the actuary.

(2) An exemption allowed under paragraph (1) of this subsection shall apply for a one-year coverage period following inception or next renewal date of all insurance policies, subscription contracts, or health care plans issued or renewed during the one-year period following the date of the exemption, after which the insurer, corporation, or health maintenance organization, or such governmental entity, shall again provide coverage for behavioral health treatment required under this subsection.

(3) An insurer, corporation, or health maintenance organization, or such governmental entity, may claim an exemption for a subsequent year, but only if the conditions specified in this subsection again are met.

(4) Notwithstanding the exemption allowed under paragraph (1) of this subsection, an insurer, corporation, or health maintenance organization, or such governmental entity, may elect to continue to provide coverage for behavioral health treatment required under this subsection.

(f) Beginning January 1, 2016, to the extent that this Code section requires benefits that exceed the essential health benefits required under Section 1302(b) of the federal Patient Protection and Affordable Care Act, P. L. 111-148, the specific benefits that exceed the required

essential health benefits shall not be required of a "qualified health plan" as defined in such act when the qualified health plan is offered in this state through the exchange. Nothing in this subsection shall nullify the application of this Code section to plans offered outside the state's exchange.

(g) This Code section shall not apply to any accident and sickness contract, policy, or benefit plan offered by any employer with ten or fewer employees.

(h) Nothing in this Code section shall be construed to limit any coverage under any accident and sickness contract policy or benefit plan, including, but not limited to, speech therapy, occupational therapy, or physical therapy otherwise available under such plan.

(i) By January 15, 2017, and every January 15 thereafter, the department shall submit a report to the General Assembly regarding the implementation of the coverage required under this Code section. The report shall include, but shall not be limited to, the following:

(1) The total number of insureds diagnosed with autism spectrum disorder;

(2) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this Code section;

(3) The cost of such coverage per insured per month; and

(4) The average cost per insured for coverage of applied behavior analysis.

All health carriers and health benefit plans subject to the provisions of this Code section shall provide the department with all data requested by the department for inclusion in the annual report. (Code 1981, § 33-24-59.10, enacted by Ga. L. 2001, p. 852, § 1; Ga. L. 2015, p. 111, §§ 2A, 2B/HB 429.)

Delayed effective date. — Ga. L. 2015, p. 111, § 3/HB 429, provides that the 2015 amendment by § 2B becomes effective on January 1, 2017, only if an amendment to the Constitution is ratified at the November, 2016, general election expressly allowing the General Assembly to appropriate funds derived from an additional .2 percent increase in the general state sales and use tax for the treatment of autism spectrum disorder. This Code section, as set out above, does not reflect the amendment by § 2B of that Act owing to the delayed effective date. After the amendment is approved, this Code section will read as follows: "(a) As used in this Code section, the term:

"(1) 'Accident and sickness contract, policy, or benefit plan' shall have the same meaning as found in Code Section 33-24-59.1. Accident and sickness contract, policy, or benefit plan shall also include without limitation any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

"(2) 'Autism' means a developmental neurological disorder, usually appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior

and severely impaired social interaction and communication skills.

"(b) An insurer that provides benefits for neurological disorders, whether under a group or individual accident and sickness contract, policy, or benefit plan, shall not deny providing benefits in accordance with the conditions, schedule of benefits, limitations as to type and scope of treatment authorized for neurological disorders, exclusions, cost-sharing arrangements, or copayment requirements which exist in such contract, policy, or benefit plan for neurological disorders because of a diagnosis of autism. The provisions of this subsection shall not expand the type or scope of treatment beyond that authorized for any other diagnosed neurological disorder."

The 2015 amendment, effective July 1, 2015, added the last sentence in paragraph (a)(1); rewrote paragraph (a)(2); added paragraphs (a)(3) and (a)(4); rewrote subsection (b); and added subsections (c) through (i).

33-24-59.12. Patient access to eye care.

Law reviews. — For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014).

JUDICIAL DECISIONS

Independent participating provider agreement violated section. — Georgia Court of Appeals correctly interpreted the Patient Access to Eye Care Act, O.C.G.A. 33-24-59.12(c)(2), and determined that an insurer's independent participating provider (IPP) agreements violated that section as the IPP prohibited providers from providing certain eye care, in particular the preparation of eyeglasses, directly to the insureds, therefore, the IPP agreement violated paragraph (c)(2). Spectera, Inc. v. Wilson, 294 Ga. 23, 749 S.E.2d 704 (2013).

Georgia Court of Appeals was incorrect in finding that an insurer's independent participating provider (IPP) agreement violated the Patient Access to Eye Care Act, O.C.G.A. 33-24-59.12(c)(5), because the IPP agreement did not in any way create the type of impermissible discrimination between classes of licensed eye care providers contemplated by paragraph (c)(5). Spectera, Inc. v. Wilson, 294 Ga. 23, 749 S.E.2d 704 (2013).

33-24-59.14. Definitions; prompt pay requirements; penalties.

JUDICIAL DECISIONS

Preemption. — Because self-funded plans would have different timeliness obligations in different states if amended state prompt-pay legislation went into effect, ERISA preempted the challenged provisions as relating to benefit plans, regardless of whether risk pooling was affected for saving clause purposes; ERISA's deemer clause applied. America's Health Ins. Plans v. Hudgens, 742 F.3d 1319 (11th Cir. 2014).

33-24-59.17. Coverage of certain abortions through certain qualified health plans prohibited; definitions.

(a) No abortion coverage shall be provided by a qualified health plan offered within the State of Georgia through a state law, a federal law, or

regulation or exchange created by the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and regulations or guidance issued under those acts, except in the case of medical emergency.

(b) For the purposes of this Code section, the term "abortion" has the same meaning as provided in Code Section 31-9A-2.

(c) For the purposes of this Code section, the term "medical emergency" has the same meaning as provided in Code Section 31-9A-2.

(d) Nothing in this Code section shall be construed as creating or recognizing a right to an abortion.

(e) It is not the intention of this Code section to make lawful an abortion that is currently unlawful. (Code 1981, § 33-24-59.17, enacted by Ga. L. 2014, p. 349, § 1/SB 98.)

Effective date. — This Code section became effective April 21, 2014.

Editor's notes. — Ga. L. 2014, p. 349, § 3/SB 98, not codified by the General Assembly, provides: "The General Assembly, by joint resolution, may appoint one or more of its members who sponsored or cosponsored this Act in his or her official capacity to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged."

Law reviews. — For article on the 2014 enactment of this Code section, see 31 Ga. St. U.L. Rev. 177 (2014).

33-24-59.18. Coverage for treatment of a terminal condition.

(a) As used in this Code section, the term:

(1) "Health benefit plan" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization, subscriber contract or agreement, preferred provider organization, accident and sickness insurance benefit plan, or other insurance contract under any other name. The term shall include any health insurance plan established under Article 1 of Chapter 18 of Title 45 and under Chapter 4 of Title 49, the "Georgia Medical Assistance Act of 1977."

(2) "Terminal condition" means any disease, illness, or health condition that a physician has diagnosed as expected to result in death in 24 months or less.

(3) "Treatment" does not include any medication or medical procedure, regardless of where actually prescribed, dispensed, or administered, which if prescribed, dispensed, or administered in this state would constitute assisted suicide in violation of Code Section 16-5-5.

(b) No health benefit plan shall restrict coverage for treatment of a terminal condition when such treatment has been prescribed by a

physician as medically appropriate and such treatment has been agreed to by an insured patient or by a person to whom the insured patient has legally delegated such authority or to whom otherwise has the legal authority to consent on behalf of the insured patient. The health benefit plan shall not refuse to pay or otherwise reimburse for the treatment diagnosed under this subsection, including any drug or device, so long as such end of life care is consistent with best practices for the treatment of the terminal condition and such treatment is supported by peer reviewed medical literature.

(c) A denial or a refusal to pay for treatment prescribed under subsection (b) of this Code section shall be a violation of this Code section.

(d) A violation of this Code section shall be a per se violation of Chapter 6 of this title, and the penalties, procedures, and remedies applicable to violations of Chapter 6 of this title shall be applicable to a violation of this Code section. (Code 1981, § 33-24-59.18, enacted by Ga. L. 2015, p. 111, § 1/HB 429.)

Effective date. — This Code section became effective July 1, 2015.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2015, Code Section 33-24-59.18, as enacted by Ga. L. 2015, p. 1317, § 1/HB 409, was redesignated as Code Section 33-24-59.19.

33-24-59.19. Coverage for treatment of burns with skin substitutes utilizing cryopreserved cadaver derived skin tissue.

No health benefit policy issued, delivered, or renewed in this state that, as a provision of hospital, medical, or surgical services, directly or indirectly covers the treatment and management of burns shall limit or exclude coverage for such treatment on the basis that the use of cryopreserved cadaver derived skin tissue is an experimental or investigational medical treatment. (Code 1981, § 33-24-59.19, enacted by Ga. L. 2015, p. 1317, § 1/HB 409.)

Effective date. — This Code section became effective July 1, 2015.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2015, Code Section 33-24-59.18, as enacted by Ga. L. 2015, p. 1317, § 1/HB 409, was redesignated as Code Section 33-24-59.19.

CHAPTER 25

LIFE INSURANCE

Sec.

33-25-4. Required nonforfeiture provisions.

(a)(1) Except as provided in subsection (f) of this Code section, no policy of life insurance issued on or after January 1, 1966, shall be delivered or issued for delivery in this state unless it shall contain the following provisions, or corresponding provisions which in the opinion of the Commissioner are at least as favorable to the defaulting or surrendering policyholder as are in the minimum requirements hereinafter specified and are essentially in compliance with subsection (h) of this Code section:

(A) A provision that, in the event of default in any premium payment, the insurer will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as specified in subsection (c) of this Code section. In lieu of such stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than 60 days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits;

(B) A provision that, upon surrender of the policy, within 60 days after the due date of any premium payment in default, after premiums have been paid for at least three full years, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as specified in subsection (b) of this Code section;

(C) A provision that a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default;

(D) A provision that, if the policy shall have become paid up by completion of all premium payments, or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the

third policy anniversary, the insurer will pay, upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value of such amount as specified in subsection (b) of this Code section;

(E) An explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions, credited to the policy, or any indebtedness to the insurer on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated in the policy, a statement that the method of computation has been filed with the supervisory insurance official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which the values and benefits are consecutively shown in the policy.

(2) Any of the provisions or portions thereof set forth in subparagraphs (a)(1)(A) through (a)(1)(E) of this Code section not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

(3) The insurer shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

(b)(1) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by subsection (a) of this Code section, shall be an amount not less than the excess, if any, of the present value on the anniversary of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of the then present value of the adjusted premiums as defined in subsections (d) and (e) of this Code section, corresponding to premiums which would have fallen due on and after the anniversary and the amount of any indebtedness to the insurer on account of or secured by the policy.

(2) Provided, however, that for any policy issued on or after the operative date of subsection (e) of this Code section as defined in subsection (e) of this Code section which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in paragraph (1) of this subsection shall be an amount not less than the sum of the cash surrender value as defined in paragraph (1) of this subsection for an

otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in paragraph (1) of this subsection for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

(3) Provided, further, that for any family policy issued on or after the operative date of subsection (e) of this Code section as defined in subsection (e) of this Code section which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age 71, the cash surrender value referred to in paragraph (1) of this subsection shall be an amount not less than the sum of the cash surrender value as defined in paragraph (1) of this subsection for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in paragraph (1) of this subsection for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

(4) Any cash surrender value available within 30 days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by subsection (a) of this Code section, shall be an amount not less than the present value on the anniversary of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on account of or secured by the policy.

(c) Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of the anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this Code section in the absence of the condition that premiums shall have been paid for at least a specified period.

(d)(1) This subsection shall not apply to policies issued on or after the operative date of subsection (e) of this Code section as defined in subsection (e) of this Code section, except that, with respect to such policies for which the gross premium during the first policy year includes any additional amounts for which no comparable additional benefit is provided during that year, this subsection shall continue to apply until the effective date of subsection (h) of this Code section. Except as provided in paragraph (3) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage or percentages of the respective premiums specified in the policy for each policy year, excluding extra premiums on a substandard policy and excluding any additional

amounts payable during the first policy year for which there are no comparable additional insurance benefits provided during that year, that the present value at the date of issue of the policy of all such adjusted premiums shall be equal to the sum of (A) the then present value of the future guaranteed benefits provided for by the policy; (B) two percent of the amount of the insurance if the insurance be uniform in amount, or of the equivalent uniform amount, as defined in paragraph (3) of this subsection, if the amount of insurance varies with the duration of the policy; (C) forty percent of the adjusted premium for the first policy year; (D) twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less, reduced by (E) any additional amounts payable during the first policy year for which there are no comparable additional insurance benefits provided during that year.

(2) The adjusted premiums shall be a single uniform percentage of the respective premiums specified in the policy for each policy year, unless the adjusted premiums result in cash surrender values which are smaller than endowment amounts provided by the policy prior to maturity as of the date or dates such endowment amounts are provided, in which event the adjusted premiums shall be determined as uniform percentages of the respective premiums specified in the policy such that no cash surrender value is smaller than any endowment amount provided by the policy prior to maturity as of the date or dates such endowment amount is provided. For the purposes of this paragraph, the Commissioner may treat any cash surrender value actually provided by the policy as equivalent to an endowment amount; provided, however, that in applying the percentages specified in items (C) and (D) of paragraph (1) of this subsection no adjusted premium shall be deemed to exceed 4 percent of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this Code section shall be the date as of which the rated age of the insured is determined.

(3) In the case of a policy providing an amount of insurance varying with the duration of the policy, the equivalent uniform amount of insurance, for the purpose of this subsection, shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration, and the benefits under which have the same present value at the date of issue as the benefits under the policy; provided, however, that, in the case of a policy providing a varying amount of insurance issued on the life of a child

under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten was the amount provided by the policy at age ten. In the case of a policy which provides pure endowment benefits which are payable without reducing the amount of insurance provided by the policy and which may be applied to provide additional amounts of paid-up life insurance, the equivalent uniform amount of insurance shall be determined on the amounts of insurance which would be effective if all the pure endowment benefits were applied to provide such additional amounts of paid-up life insurance.

(4) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (A) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (B) the adjusted premiums for such term insurance, items (A) and (B) of this paragraph being calculated separately and as specified in paragraphs (1) through (3) of this subsection, except that, for the purpose of items (B), (C), and (D) of paragraph (1) of this subsection, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in item (B) of this paragraph shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in item (A) of this paragraph.

(5) All adjusted premiums and present values referred to in this Code section shall, for all policies of ordinary insurance, be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table, provided that, for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured. Such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table; provided, however, that any insurer may file with the Commissioner a written notice of its election that such adjusted premiums and present values shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table, after a specified date before January 1, 1968, and, whether or not any election has been made, such calculations for all policies of industrial insurance, issued on or after January 1, 1968, shall be made on the basis of the Commissioners 1961 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Such rate of interest shall not exceed 3 1/2 percent per annum, except that a rate of interest not

exceeding 4 percent per annum may be used for policies issued on or after July 1, 1973; and prior to July 1, 1979, a rate of interest not exceeding 5 1/2 percent per annum may be used for policies issued on or after July 1, 1979; and for any single premium whole life or endowment insurance policy, a rate of interest not exceeding 6 1/2 percent per annum may be used. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed in the case of ordinary policies may not be more than those shown in the Commissioners 1958 Extended Term Insurance Table and in the case of industrial policies may not be more than 130 percent of the rates of mortality according to the 1941 Standard Industrial Mortality Table. After January 1, 1968, when the Commissioners 1961 Standard Industrial Mortality Table becomes applicable, such rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the Commissioner.

(e)(1) As used in this subsection, the term "operative date of the valuation manual" means January 1 of the first calendar year that the valuation manual as defined in subsection (o) of Code Section 33-1-10 becomes effective.

(1.1) This subsection shall apply to any life insurance policy issued on or after January 1, 1989, or such earlier date as may have been elected by the insurer with respect to such policy in accordance with the provisions of paragraph (11) of this subsection. Except as provided in paragraph (3) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of (A) the then present value of the future guaranteed benefits provided for by the policy; (B) one percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (C) 125 percent of the nonforfeiture net level premium as defined in this subsection; provided, however, that in applying the percentage specified in item (C) of this paragraph no nonforfeiture net level premium shall be deemed to exceed 4 percent

of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(3) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that the future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in paragraph (7) of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of (A) the sum of (i) the then present value of the then future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (A) 1 percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no

previous change, the date of issue of the policy; and (B) 125 percent of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where:

(A) Equals the sum of:

(i) The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(ii) The present value of the increase in future guaranteed benefits provided for by the policy; and

(B) Equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) Notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(8) All adjusted premiums and present values referred to in this Code section shall for all policies of ordinary insurance be calculated on the basis of (A) the Commissioners 1980 Standard Ordinary Mortality Table or (B) at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection for policies issued in that calendar year; provided, however, that:

(A) At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year;

(B) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (a) of this Code section, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any;

(C) An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values;

(D) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance;

(E) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables;

(F) For policies issued prior to the operative date of the valuation manual, any Commissioners standard ordinary mortality tables adopted after 1980 by the National Association of Insurance Commissioners that are approved by regulation promulgated by the Commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the Commissioner approves by regulation any Commissioners standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual; and

(G) For policies issued prior to the operative date of the valuation manual, any Commissioners standard industrial mortality

tables adopted after 1980 by the National Association of Insurance Commissioners that are approved by regulation promulgated by the Commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the Commissioner approves by regulation any Commissioners standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(9) The nonforfeiture interest rate is defined as follows:

(A) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to 125 percent of the calendar year statutory valuation interest rate for such policy as defined in Code Section 33-10-13, the Standard Valuation Law, rounded to the nearer one quarter of 1 percent; provided, however, that the nonforfeiture interest rate shall not be less than 4.00 percent.

(B) For policies issued on and after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(10) Notwithstanding any other provision in this title to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(11) After November 1, 1982, any insurer may file with the Commissioner a written notice of its election to comply with the provisions of this subsection with respect to specified policy forms after a specified date before January 1, 1989, which shall be the operative date of this subsection for such specified policy forms. If an

insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1989.

(f) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in subsections (a), (b), (c), (d), or (e) of this Code section, then:

(1) The Commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsections (a) through (e) of this Code section;

(2) The Commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

(3) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Code section, as determined by regulations promulgated by the Commissioner.

(g) Any cash surrender value and any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary, except that, in the case of industrial insurance, proportionate increases in value may be calculated on the basis of quarter-year payment. All values referred to in subsections (b) through (e) of this Code section may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding subsection (b) of this Code section, additional benefits payable (1) in the event of death or dismemberment by accident or accidental means; (2) in the event of total and permanent disability; (3) as reversionary annuity or deferred reversionary annuity benefits; (4) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this Code section would not apply; (5) as term insurance on the life of a child, or on the lives of children provided in a policy on the life of a parent of the child, if the term insurance expires before the child attains age 26, is uniform in amount after the child attains age one and has not become paid up by reason of the death of a parent of the child; or (6) as other policy benefits additional to life insurance and endowment

benefits, and premiums for all such additional benefits shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this Code section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(h)(1) This subsection, in addition to all other applicable subsections of this Code section, shall apply to all policies issued on or after January 1, 1986, except that, with respect to such policies for which the gross premium during the first policy year includes any additional amounts for which no comparable additional benefit is provided during that year, this subsection shall apply to any such policies issued after a specified operative date before January 1, 1986, as defined in subsection (e) of this Code section. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two tenths of 1 percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of (A) the greater of zero and the basic cash value hereinafter specified and (B) the present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy.

(2) The basic cash value shall be equal to the present value on such anniversary of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary; provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (b) or (d) of this Code section, whichever is applicable, shall be the same as are the effects specified in subsection (b) or (d) of this Code section, whichever is applicable, on the cash surrender values defined in that subsection.

(3) The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (d) or (e) of this Code section, whichever is applicable. Except as is required by paragraph (4) of this subsection, such percentage:

(A) Must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any

indebtedness, of at least two tenths of 1 percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

(B) Must be such that no percentage after the later of the two policy anniversaries specified in subparagraph (A) of this paragraph may apply to fewer than five consecutive policy years.

(4) Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (d) or (e) of this Code section, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(5) All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this Code section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

(6) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (a), (b), (c), (e), and (g) of this Code section. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (1) through (6) in subsection (g) of this Code section shall conform with the principles of this subsection.

(i) This Code section shall not apply to any of the following:

(1) Reinsurance;

(2) Group insurance;

(3) Pure endowment;

(4) Annuity or reversionary annuity contract;

(5) Term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

(6) Term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted

premium, calculated as specified in subsections (d) and (e) of this Code section, is less than the adjusted premium so calculated on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy; or

(7) Policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (b), (c), (d), and (e) of this Code section, exceeds 2 1/2 percent of the amount of insurance at the beginning of the same policy year.

For purposes of determining the applicability of this Code section, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life. (Code 1933, § 56-2504, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1962, p. 487, §§ 2, 3; Ga. L. 1973, p. 617, § 2; Ga. L. 1979, p. 1407, § 2; Ga. L. 1981, p. 936, §§ 3, 4; Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 650, § 3; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 149, § 33; Ga. L. 1986, p. 10, § 33; Ga. L. 2015, p. 846, § 2/HB 185.)

The 2015 amendment, effective July 1, 2015, added present paragraph (e)(1) and redesignated former paragraph (e)(1) as paragraph (e)(1.1); in subparagraph (e)(8)(F), substituted "For policies issued prior to the operative date of the valuation manual, any Commissioners standard" for "Any" at the beginning, and added the last two sentences; in subparagraph (e)(8)(G), substituted "For policies issued prior to the operative date of the valuation manual, any Commissioners standard" for "Any" at the beginning and added the last two sentences; and rewrote paragraph (e)(9).

33-25-11. Cash surrender value and proceeds of life insurance policies and annuity contracts not liable to attachment, garnishment, or legal process in favor of creditors; proceeds becoming part of insured's estate.

Law reviews. — For annual survey on bankruptcy law, see 64 Mercer L. Rev. 849 (2013).

JUDICIAL DECISIONS

Scope of protection.

Bankruptcy court did not err in concluding that O.C.G.A. § 33-25-11 did not provide the bankruptcy debtor an exemption from the bankruptcy estate because O.C.G.A. § 44-13-100 prevailed over the more general provisions of § 33-25-11. McFarland v. Wallace, 516 B.R. 665 (S.D. Ga. 2014).

33-25-14. Unclaimed life insurance benefits; purpose; definitions; insurer conduct.

(a) This Code section shall be known and may be cited as the "Unclaimed Life Insurance Benefits Act."

(b) This Code section shall require recognition of the escheat or unclaimed property statutes of this state and require the complete and proper disclosure, transparency, and accountability relating to any method of payment for life insurance death benefits regulated by the Insurance Department; provided, however, that neither the Commissioner nor the State Treasurer shall promulgate regulations or issue bulletins that impose, or interpret this Code section to impose, additional duties and obligations on insurers, beyond those set forth in this Code section, or otherwise attempt to expand the requirements of this Code section.

(c) As used in this Code section, the term:

(1) "Account owner" means the owner of a retained asset account who is a resident of this state.

(2) "Annuity" means an annuity contract issued in this state. The term "annuity" shall not include any annuity contract used to fund an employment-based retirement plan or program where the insurer takes direction from the plan sponsor and plan administrator.

(3) "Death Master File" means the Social Security Administration's Death Master File or any other data base or service that is at least as comprehensive as the Social Security Administration's Death Master File for determining that a person has reportedly died.

(4) "Death Master File match" means a search of the Death Master File that results in a match of a person's name and social security number or the name and date of birth.

(5) "Insurer" means a life insurance company authorized to transact the class of insurance designated in Code Section 33-3-5 as Class (1).

(6) "Knowledge of death" means, for purposes of this chapter and Article 5 of Chapter 12 of Title 44:

(A) A receipt of an original or valid copy of a certified death certificate; or

(B) A Death Master File match validated by a secondary source by the insurer.

(7) "Person" means the policy owner, insured, annuity owner, annuitant, or account owner, as applicable under the policy, annuity, or retained asset account subject to this Code section.

(8) "Policy" means any policy or certificate of life insurance issued in this state. The term "policy" shall not include:

(A) Any policy or certificate of life insurance that provides a death benefit under an employee benefit plan subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1002, as periodically amended, or under any federal employee benefit program;

(B) Any policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement;

(C) Any policy or certificate of credit life or accidental death insurance; or

(D) Any policy issued to a group master policyholder for which the insurer does not provide record keeping services.

(9) "Record keeping services" means those circumstances under which the insurer has agreed with a group policyholder to be responsible for obtaining, maintaining, and administering in its own systems information about each individual insured under an insured's group insurance contract, or a line of coverage thereunder, at least the following information:

(A) Social security number or name and date of birth;

(B) Beneficiary designation information;

(C) Coverage eligibility;

(D) Benefit amount; and

(E) Premium payment status.

(d)(1)(A) An insurer shall perform a comparison of its in-force policies, annuities, and retained asset accounts issued in this state against a Death Master File, on at least a semiannual basis, to identify potential Death Master File matches.

(B) An insurer may comply with the requirements of this subsection by using the full Death Master File once and thereafter using the Death Master File update files for future comparisons.

(C) Nothing in this subsection shall limit the insurer from requesting a valid death certificate as part of any claims validation process.

(2)(A) If an insurer learns of the possible death of a person, through a Death Master File match or otherwise, then the insurer shall within 90 days:

(i) Complete a good faith effort, which shall be documented by the insurer, to confirm the death of the person against other available records and information;

(ii) Review its records to determine whether the deceased person had purchased any other products with the insurer;

(iii) Determine whether benefits may be due in accordance with any applicable policy, annuity, or retained asset account; and

(iv) If the beneficiary or other authorized representative has not communicated with the insurer within the 90 day period, take reasonable steps, which shall be documented by the insurer, to locate and contact the beneficiary or beneficiaries or other authorized representative on any such policy, annuity, or retained asset account, including but not limited to sending the beneficiary information regarding the insurer's claims process, including the need to provide an official death certificate if applicable under the policy, annuity, or retained asset account.

(B) In the event the insurer is unable to confirm the death of a person following a Death Master File match, an insurer may consider such policy, annuity, or retained asset account to be in-force in accordance with its terms.

(3) To the extent permitted by law, an insurer may disclose minimum necessary personal information about a person or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer in locating the beneficiary or a person otherwise entitled to payment of the claims proceeds.

(4) An insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a Death Master File search or verification of a Death Master File match conducted pursuant to this subsection.

(5) The benefits from a life insurance policy, annuity, or retained asset account, plus any applicable accrued interest, shall be payable pursuant to the terms of the contract or, if applicable, in accordance with probate law. In the event the proper recipients cannot be found, the benefits shall escheat to the state as unclaimed property pursuant to Code Section 44-12-198. Interest payable under Code Section 33-25-10 shall not be payable as unclaimed property under Code Section 44-12-198.

(6) The Commissioner may adopt such rules and regulations as may be reasonably necessary to implement the provisions of this subsection.

(7) The Commissioner may, in his or her reasonable discretion, make an order:

(A) Limiting an insurer's Death Master File comparisons required under paragraph (1) of this subsection to the insurer's

electronic searchable files or approving a plan and timeline for conversion of the insurer's files to electronic searchable files;

(B) Exempting an insurer from the Death Master File comparisons required under paragraph (1) of this subsection or permitting an insurer to perform such comparisons less frequently than semiannually upon a demonstration of financial hardship by the insurer; or

(C) Phasing in compliance with this subsection according to a plan and timeline approved by the Commissioner.

(8) Failure to meet any requirement of this subsection with such frequency as to constitute a general business practice is a violation of Chapter 6 of this title. Nothing herein shall be construed to create or imply a private cause of action for a violation of this subsection.

(e) In the event that an insurer:

(1) Has identified a person as deceased through a Death Master File match through a search described in paragraph (1) of subsection (d) of this Code section or other information source;

(2) Has validated such information through a secondary information source; and

(3) Is unable to locate a beneficiary located in this state under the policy, annuity, or retained asset account after conducting reasonable search efforts during the period of up to one year after the insurer's validation of the Death Master File match, or if no beneficiary, if the person, as applicable for unclaimed reporting purposes, has a last known address in this state,

then the insurer is authorized to report and remit the proceeds of such policy, annuity, or retained asset account due to this state on an early reporting basis, without further notice or consent by the state, after attempting to contact such beneficiary pursuant to Code Section 44-12-198. Once reported and proceeds remitted, the insurer shall be relieved and indemnified from any and all additional liability to any person relating to the proceeds reported and remitted, including but not limited to any liability under Code Section 44-12-214 for all proceeds reported and remitted to the state pursuant to this subsection. This indemnification from liability shall be in addition to any other protections provided by law. (Code 1981, § 33-25-14, enacted by Ga. L. 2014, p. 233, § 1/HB 920.)

Effective date. — This Code Section became effective July 1, 2014. See editor's note for applicability.

Editor's notes. — Ga. L. 2014, p. 233, § 2/HB 920, not codified by the General Assembly, provides: "This Act shall be applicable to policies issued or renewed on or after January 1, 2015."

CHAPTER 29

INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

33-29-22. Notice of premium increase; notification of impact of Patient Protection and Affordable Care Act.

(a) Notice of any premium increase shall be mailed or delivered to each holder of an individual accident and sickness insurance policy not less than 60 days prior to the effective date of such increase.

(b) (Repealed effective December 31, 2014) Concurrently with any notice of premium increase or offer of new coverage because of discontinuance or termination of an existing plan of coverage, an insurer shall provide an estimate as to the amount or percentage of any premium increase which is attributable to the Patient Protection and Affordable Care Act. Such notices shall include the following statement: "These increases are due to the federal Patient Protection and Affordable Care Act and not the enactment of any laws or regulations of the Governor of Georgia, the Georgia General Assembly, or the Georgia Department of Insurance." This subsection shall stand repealed on December 31, 2014. (Code 1981, § 33-29-22, enacted by Ga. L. 1999, p. 289, § 4; Ga. L. 2013, p. 1100, § 1/SB 236; Ga. L. 2014, p. 866, § 33/SB 340.)

The 2014 amendment, effective April 29, 2014, part of an Act to revise, modernize, and correct the Code, substituted "subsection" for "paragraph" in subsection (b).

CHAPTER 29A

INDIVIDUAL HEALTH INSURANCE COVERAGE

Article 1

Availability and Assignment System

ARTICLE 1

AVAILABILITY AND ASSIGNMENT SYSTEM

33-29A-9. Discontinuance of state assignment system benefit plans.

(a) Upon the effective date whereupon guaranteed issue coverage is available pursuant to the federal Patient Protection and Affordable Care Act, a health insurer or managed care organization shall not be required to offer health care policies under the Georgia Health Insurance Assignment System and Georgia Health Benefits Assignment System.

(b) Each health insurer or managed care organization that has offered health care policies under the Georgia Health Insurance Assignment System and the Georgia Health Benefits Assignment System may terminate, cancel, or nonrenew such existing policies as of the date upon which guaranteed issue coverage is available pursuant to the federal Patient Protection and Affordable Care Act, provided that the health insurer or managed care organization provides at least 90 days' notice prior to the termination of the coverage to all policyholders and to the Commissioner.

(c) An insurer may not terminate, cancel, or nonrenew any policy under this subsection if, at the end of the 90 day cancellation period, the insured would not have at least 90 days of remaining open enrollment to obtain insurance coverage through an exchange created pursuant to the federal Patient Protection and Affordable Care Act. (Code 1981, § 33-29A-9, enacted by Ga. L. 2013, p. 873, § 3/HB 389; Ga. L. 2014, p. 866, § 33/SB 340.)

The 2014 amendment, effective April 29, 2014, part of an Act to revise, modernize, and correct the Code, redesignated the former introductory paragraph as subsection (a); redesignated former paragraphs (1) and (2) as subsections (b) and (c), respectively; and substituted "subsection" for "paragraph" in subsection (c).

CHAPTER 29B

HEALTH CARE COVERAGE FOR CHILDREN

Sec.
33-29B-1 through 33-29B-8.

33-29B-1 through 33-29B-8.

Repealed by Ga. L. 2012, p. 617, § 1/HB 1166, effective January 1, 2014.

Editor's notes. — This chapter consisted of Code Sections 33-29B-1 through 33-29B-8, relating to health care coverage for children, and was based on Code 1981, §§ 33-29B-1 through 33-29B-8, enacted by Ga. L. 2012, p. 617, § 1/HB 1166.

CHAPTER 30

GROUP OR BLANKET ACCIDENT AND SICKNESS INSURANCE

Article 1

General Provisions

ARTICLE 1

GENERAL PROVISIONS

33-30-13. Notices of premium increases to be mailed or delivered to group policyholder; notification of impact of federal Patient Protection and Affordable Care Act.

(a) Notice of the maximum amount of a group premium increase shall be mailed or delivered to the group policyholder and to each employer group or subgroup insured under the group policy not less than 60 days prior to the effective date of the premium increase.

(b) The commissioner of community health shall also provide notice to each person covered under the health insurance plans established pursuant to Article 1 of Chapter 18 of Title 45 when any premium increase occurs of how much of such increase is attributable to the federal Patient Protection and Affordable Care Act. (Code 1981, § 33-30-29, enacted by Ga. L. 1990, p. 1402, § 5; Code 1981, § 33-30-13, as redesignated by Ga. L. 1991, p. 94, § 33; Ga. L. 2013, p. 1100, § 2/SB 236; Ga. L. 2014, p. 866, § 33/SB 340; Ga. L. 2015, p. 5, § 33/HB 90.)

The 2014 amendment, effective April 29, 2014, part of an Act to revise, modernize, and correct the Code, substituted "subsection" for "paragraph" in the last sentence of subsection (b).

The 2015 amendment, effective

March 13, 2015, part of an Act to revise, modernize, and correct the Code, deleted former subsection (b), which read: "Concurrently with any notice of premium increase or offer of new coverage because of discontinuance or termination of an existing plan of coverage, an insurer shall provide an estimate as to the amount or percentage of any premium increase which is attributable to the Patient Protection and Affordable Care Act. Such notices shall include the following statement: 'These increases are due to the federal Patient Protection and Affordable Care Act and not the enactment of any laws or regulations of the Governor of Georgia, the Georgia General Assembly, or the Georgia Department of Insurance.' This subsection shall stand repealed on December 31, 2014."; and redesignated former subsection (c) as present subsection (b).

ARTICLE 2

PREFERRED PROVIDER ARRANGEMENTS

33-30-21. Legislative intent.

JUDICIAL DECISIONS

Discovery on health care costs. — In a hospital lien case, the trial court erred by granting a patient's motion to compel seeking discovery from a medical center as to the center's rate-setting agreements with insurers and the center's revenue and other information because the patient was uninsured and such discovery was not relevant nor reasonably calculated to lead to admissible evidence. Med. Ctr., Inc. v. Bowden, 327 Ga. App. 714, 761 S.E.2d 116 (2014).

33-30-23. Standards; payments or reimbursement for noncontracting provider of covered services; filing requirements for unlicensed entities; provision for payment solely to provider.

JUDICIAL DECISIONS

ERISA preemption.

In a hospital lien case, the trial court erred by granting a patient's motion to compel seeking discovery from a medical center as to the center's rate-setting agreements with insurers and the center's revenue and other information because the patient was uninsured and such discovery was not relevant nor reasonably calculated to lead to admissible evidence. Med. Ctr., Inc. v. Bowden, 327 Ga. App. 714, 761 S.E.2d 116 (2014).

CHAPTER 32

PROPERTY INSURANCE

33-32-1. Standard fire policy.

Law reviews. — For annual survey on insurance, see 65 Mercer L. Rev. 135 (2013).

CHAPTER 36

GEORGIA INSURERS INSOLVENCY POOL

33-36-20. Liability of pool to claimants and electing insureds in emergency circumstances; definitions; exceptions.

JUDICIAL DECISIONS

Employee's failure to prove insolvency. — Employee seeking workers' compensation from the Georgia Insurers Insolvency Pool failed to prove that the employer was insolvent as required for recovery under O.C.G.A. § 33-36-20(b)(2) and (3) based on the owner's non-credible testimony that the owner had sold the company and that the buyer had defaulted on the buyer's loans from the owner. Reece v. Ga. Insurers Insolvency Pool, 324 Ga. App. 437, 750 S.E.2d 746 (2013).

CHAPTER 37

INSURERS REHABILITATION AND LIQUIDATION

Article 1

General Provisions

Article 3

Procedure for Rehabilitation

ARTICLE 1

GENERAL PROVISIONS

33-37-1. Construction and purpose of chapter.

JUDICIAL DECISIONS

Claims in common with the insolvent trust fund versus personal claims. — Trial court erred in dismissing the plaintiffs' breach of contract, misrepresentation, and other claims against a workers compensation trust fund because while the court properly concluded that the Georgia Insurance Commissioner, as an appointed receiver, had the exclusive authority to prosecute legal claims that were common to the insolvent trust fund, the court erred in finding that plaintiffs did not have standing to prosecute claims that were personal in nature and not common to the trust fund. Superior Roofing Co. of Ga., Inc. v. Am. Prof'l Risk Servs., 323 Ga. App. 416, 744 S.E.2d 400 (2013).

33-37-3. Definitions.

As used in this chapter, the term:

(1) "Ancillary state" means any state other than a domiciliary state.

(2) "Commissioner" means the Commissioner of Insurance.

(3) "Creditor" means a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

(4) "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer and any summary proceeding under Code Section 33-37-9. "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(5) "Doing business" includes any of the following acts, whether effected by mail or otherwise:

(A) The issuance or delivery of contracts of insurance to persons resident in this state;

(B) The solicitation of applications for such contracts or other negotiations preliminary to the execution of such contracts;

(C) The collection of premiums, membership fees, assessments, or other consideration for such contracts;

(D) The transaction of matters subsequent to execution of such contracts and arising out of them; or

(E) Operating under a license or certificate of authority, as an insurer, issued by the Insurance Department.

(6) "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

(7) "Fair consideration" means:

(A) When in exchange for property or obligation as a fair equivalent therefor and in good faith, property is conveyed, services are rendered, an obligation is incurred, or an antecedent debt is satisfied; or

(B) When property or obligation is received in good faith to secure a present advance or antecedent, debt in amount not disproportionately small as compared to the value of the property or obligation obtained.

(7.1) "Federal home loan bank" means a federal home loan bank established under the federal Home Loan Bank Act, 12 U.S.C. Section 1421, et seq.

(8) "Foreign country" means any other jurisdiction not in any state.

(9) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors in more than a single state shall be treated as general assets.

(10) "Guaranty association" means the Georgia Insurers Insolvency Pool created by Chapter 36 of this title, the Georgia Life and Health Insurance Guaranty Association created by Chapter 38 of this title, and any other similar entity now or hereafter created by the General Assembly for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entities now in existence in or hereafter created by the legislature of any other state.

(11) "Insolvency" or "insolvent" means:

(A) For an insurer issuing only assessable fire insurance policies:

(i) The inability to pay any obligation within 30 days after it becomes payable; or

(ii) If an assessment is made within 30 days after an obligation becomes payable, the inability to pay such obligation 30 days

following the date specified in the first assessment notice issued after the date of loss;

(B) For any other insurer, the inability to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

(i) Any capital and surplus required by law for its organization; or

(ii) The total par or stated value of its authorized and issued capital stock; and

(C) As to any insurer licensed to do business in this state as of July 1, 1991, which does not meet the standard established under subparagraph (B) of this paragraph, for a period not to exceed three years from July 1, 1991, the inability to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the Commissioner under provisions of this title.

For purposes of this paragraph, "liabilities" shall include, but not be limited to, reserves required by statute or by regulations or specific requirements imposed by the Commissioner upon a subject company at the time of admission or subsequent thereto.

(12) "Insurer" means any person who has done, purports to do, is doing, or is licensed to do an insurance business and is or has been subject to liquidation, rehabilitation, reorganization, supervision, the authority of, or conservation by any state insurance regulatory official. For purposes of this chapter, any other persons included under Code Section 33-37-2 shall be deemed to be insurers.

(12.1) "Insurer-member" means an insurer who is a member of a federal home loan bank.

(13) "Preferred claim" means any claim with respect to which the terms of this chapter accord priority of payment from the general assets of the insurer.

(14) "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context requires.

(15) "Reciprocal state" means any state other than this state in which in substance and effect Code Sections 33-37-17, 33-37-51, 33-37-52, and 33-37-54 through 33-37-56 are in force, and in which provisions are in force requiring that the Commissioner or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

(16) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

(17) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

(18) "State" means any state, district, or territory of the United States.

(19) "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property, an interest therein, the possession thereof or of fixing a lien upon property or upon an interest therein, whether absolutely or conditionally, voluntarily, or by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor. (Code 1981, § 33-37-3, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2015, p. 377, § 2-1/HB 552.)

The 2015 amendment, effective July 1, 2015, added paragraphs (7.1) and (12.1).

33-37-5. Grounds for restraining orders and injunctions; rights regarding collateral pledged by insurer-member; process and timeline; options for renewal or restructuring of loan.

(a) Any receiver appointed in a proceeding under this chapter may at any time apply for, and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

(1) The transaction of further business;

(2) The transfer of property;

(3) Interference with the receiver or with a proceeding under this chapter;

(4) Waste of the insurer's assets;

(5) Dissipation and transfer of bank accounts;

(6) The institution or further prosecution of any actions or proceedings;

(7) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets, or its policyholders;

(8) The levying of execution against the insurer, its assets, or its policyholders;

(9) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

(10) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(11) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of any proceeding under this chapter.

(b) The receiver may apply to any court outside of the state for the relief described in subsection (a) of this Code section.

(c)(1) After the seventh day following the filing of a delinquency proceeding, a federal home loan bank shall not be stayed or prohibited from exercising its rights regarding collateral pledged by an insurer-member.

(2) If a federal home loan bank exercises its rights regarding collateral pledged by an insurer-member who is subject to a delinquency proceeding, the federal home loan bank shall repurchase any outstanding capital stock that is in excess of that amount of federal home loan bank stock that the insurer-member is required to hold as a minimum investment to the extent the federal home loan bank in good faith determines the repurchase to be permissible under applicable laws, regulations, regulatory obligations, and the federal home loan bank's capital plan and consistent with the federal home loan bank's current capital stock practices applicable to its entire membership.

(d) Following the appointment of a receiver for an insurer-member, the federal home loan bank shall, within ten business days after a request from the receiver, provide a process and establish a timeline for all of the following:

(1) The release of collateral that exceeds the amount required to support secured obligations remaining after any repayment of loans as determined in accordance with the applicable agreements between the federal home loan bank and the insurer-member;

(2) The release of any of the insurer-member's collateral remaining in the federal home loan bank's possession following repayment of all outstanding secured obligations of the insurer-member in full;

(3) The payment of fees owed by the insurer-member and the operation of deposits and other accounts of the insurer-member with the federal home loan bank; and

(4) The possible redemption or repurchase of federal home loan bank stock or excess stock of any class that an insurer-member is required to own.

(e) Upon request from a receiver, the federal home loan bank shall provide any available options for an insurer-member subject to a delinquency proceeding to renew or restructure a loan to defer associated prepayment fees, subject to market conditions, the terms of any loans outstanding to the insurer-member, the applicable policies of the federal home loan bank, and the federal home loan bank's compliance with federal laws and regulations. (Code 1981, § 33-37-5, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2015, p. 377, § 2-2/HB 552.)

The 2015 amendment, effective July 1, 2015, added subsections (c) through (e).

33-37-8.1. Immunity of receivers and employees; indemnification; attorney's fees; approval of settlement; applicability of provisions.

JUDICIAL DECISIONS

Sovereign immunity waived in part. — Provisions of the Insurers Rehabilitation and Liquidation Act, O.C.G.A. § 33-37-1 et seq., allowing the trial court to review and audit the state's conduct as receiver, did not waive the state's sovereign immunity with respect to amounts that were improperly charged to a liquidated insurer's estate, and the state was not required to repay such amounts; however, under O.C.G.A. § 33-37-8.1(b), sovereign immunity was waived for intentional or willful or wanton misconduct. State ex rel. Hudgens v. Sun States Insurance Group, Inc., 770 S.E.2d 43, No. A14A2120, 2015 Ga. App. LEXIS 214 (2015).

ARTICLE 3

PROCEDURE FOR REHABILITATION

33-37-17. Commissioner appointed as liquidator; seizure and administration of assets; effect of filing order; petition for declaration of insolvency; financial reports; plan for continued performance pending appeal.

JUDICIAL DECISIONS

Cited in State ex rel. Hudgens v. Sun States Insurance Group, Inc., 770 S.E.2d 43, No. A14A2120, 2015 Ga. App. LEXIS 214 (2015).

33-37-20. Powers of liquidator.

JUDICIAL DECISIONS

Claims in common with the insolvent trust fund versus personal claims. — Trial court erred in dismissing the plaintiffs' breach of contract, misrepresentation, and other claims against a workers compensation trust fund because while the court properly concluded that the Georgia Insurance Commissioner, as an appointed receiver, had the exclusive authority to prosecute legal claims that were common to the insolvent trust fund, the court erred in finding that the plaintiffs did not have standing to prosecute claims that were personal in nature and not common to the trust fund. Superior Roofing Co. of Ga., Inc. v. Am. Prof'l Risk Servs., 323 Ga. App. 416, 744 S.E.2d 400 (2013).

Cited in State ex rel. Hudgens v. Sun States Insurance Group, Inc., 770 S.E.2d 43, No. A14A2120, 2015 Ga. App. LEXIS 214 (2015).

33-37-23. Stay of collateral proceedings against insurer; authority of liquidator to intervene in, and defend, out-of-state action.

JUDICIAL DECISIONS

Claims in common with the insolvent trust fund versus personal claims. — Trial court erred in dismissing the plaintiffs' breach of contract, misrepresentation, and other claims against a workers compensation trust fund because while the court properly concluded that the Georgia Insurance Commissioner, as an appointed receiver, had the exclusive authority to prosecute legal claims that were common to the insolvent trust fund, the court erred in finding that the plaintiffs did not have standing to prosecute claims that were personal in nature and not common to the trust fund. Superior Roofing Co. of Ga., Inc. v. Am. Prof'l Risk Servs., 323 Ga. App. 416, 744 S.E.2d 400 (2013).

33-37-26.1. Limitations on ability of receiver to void transfer of certain property in connection with federal home loan bank security agreement; transfer avoidance under certain circumstances.

The receiver for an insurer-member shall not void any transfer of, or any obligation to transfer, money or any other property arising under or in connection with any federal home loan bank security agreement; any pledge, security, collateral, or guarantee agreement; or any other similar arrangement or credit enhancement relating to a federal home loan bank security agreement made in the ordinary course of business and in compliance with the applicable federal home loan bank agreement. However, a transfer may be avoided under this Code section if the transfer was made with intent to hinder, delay, or defraud the insurer-member, the receiver for the insurer-member, or existing or future creditors. This Code section shall not affect a receiver's rights regarding advances to an insurer-member in delinquency proceedings

pursuant to 12 C.F.R. Section 1266.4. (Code 1981, § 33-37-26.1, enacted by Ga. L. 2015, p. 377, § 2-3/HB 552.)

Effective date. — This Code section became effective July 1, 2015.

33-37-45. Liquidator's application for discharge.

JUDICIAL DECISIONS

State's sovereign immunity not waived. — Provisions of the Insurers Rehabilitation and Liquidation Act, O.C.G.A. § 33-37-1 et seq., allowing the trial court to review and audit the state's conduct as receiver, did not waive the state's sovereign immunity with respect to amounts that were improperly charged to a liquidated insurer's estate, and the state was not required to repay such amounts; however, under O.C.G.A. § 33-37-8.1(b), sovereign immunity was waived for intentional or willful or wanton misconduct. State ex rel. Hudgens v. Sun States Insurance Group, Inc., 770 S.E.2d 43, No. A14A2120, 2015 Ga. App. LEXIS 214 (2015).

33-37-48. Receivership audits.

JUDICIAL DECISIONS

State's sovereign immunity not waived. — Provisions of the Insurers Rehabilitation and Liquidation Act, O.C.G.A. § 33-37-1 et seq., allowing the trial court to review and audit the state's conduct as receiver, did not waive the state's sovereign immunity with respect to amounts that were improperly charged to a liquidated insurer's estate, and the state was not required to repay such amounts; however, under O.C.G.A. § 33-37-8.1(b), sovereign immunity was waived for intentional or willful or wanton misconduct. State ex rel. Hudgens v. Sun States Insurance Group, Inc., 770 S.E.2d 43, No. A14A2120, 2015 Ga. App. LEXIS 214 (2015).

CHAPTER 41

CAPTIVE INSURANCE COMPANIES

33-41-2. Definitions.

Terms not otherwise defined in this chapter shall have the same meaning ascribed to them in this title. As used in this chapter, unless the context otherwise requires, the term:

(1) "Affiliate" means an individual, partnership, corporation, trust, or estate that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with one or more of the shareholders or members of a captive insurance company. Affiliates shall also include employees of any shareholder or member, or any affiliate thereof, of a captive insurance company. For the purpose of the foregoing definition of affiliate, "control" means:

(A) Ownership of shares of a corporation possessing 50 percent or more of the total voting power of all classes of shares entitled to vote or possessing 50 percent or more of the total value of the outstanding shares of the corporation; and

(B) Ownership of 50 percent or more by value of the beneficial interests in a partnership, trust, or estate.

(2) "Association" means any membership organization whose members consist of a group of individuals, corporations, partnerships, or other associations who engage in similar or related professional, trade, or business activities and who collectively own, control, or hold with power to vote all of the outstanding voting interests of an association captive insurance company or of a corporation that is the sole shareholder of an association captive insurance company.

(3) "Association captive insurance company" means any domestic insurance company granted a certificate of authority under this chapter to insure or reinsure the similar or related risks of members and affiliates of members of its association.

(4) "Captive insurance company" means any pure captive insurance company, association captive insurance company, industrial insured captive insurance company, or risk retention group captive insurance company.

(5) "Controlled unaffiliated business" means:

(A) A person:

(i) That is not an affiliate;

(ii) That has an existing contractual relationship with an affiliate under which the affiliate bears a potential financial loss; and

(iii) The risks of which are managed by a captive insurance company under an arrangement approved by the Commissioner; or

(B) A reinsurance pooling arrangement with other captive insurance companies that is approved by the Commissioner.

(6) "Industrial insured" means an insured:

(A) Who procures the insurance of any risk or risks through the use of the services of a full-time employee who acts as an insurance manager, risk manager, or insurance buyer or through the services of a person licensed as a property and casualty agent, broker, or counselor in such person's state of domicile;

(B) Whose aggregate annual premiums for insurance on all risks total at least $25,000.00; and

(C) Who either:

(i) Has at least 25 full-time employees;

(ii) Has gross assets in excess of $3 million; or

(iii) Has annual gross revenues in excess of $5 million.

(7) "Industrial insured captive insurance company" means any domestic insurance company granted a certificate of authority under this chapter to insure or reinsure the risks of industrial insureds and their affiliates and which has as its shareholders or members only industrial insureds that are insured or reinsured by the industrial insured captive insurance company or which has as its sole shareholder or sole member a corporation whose only shareholders are industrial insureds that are insured or reinsured by the industrial insured captive insurance company.

(8) "Parent" means a corporation which directly owns shares representing more than 50 percent of the total outstanding voting power and value of a pure captive insurance company.

(9) "Pure captive insurance company" means any domestic insurance company granted a certificate of authority under this chapter to insure or reinsure the risks of its parent and affiliates of its parent, and controlled unaffiliated business.

(10) "Risk retention group captive insurance company" is any pure, association, or industrial insured captive insurance company which has been granted a certificate of authority under this chapter and determined by the Commissioner to be established and maintained as a "risk retention group" as defined under the federal Liability Risk Retention Act of 1986, as amended. A risk retention group may be chartered and licensed either under this chapter or under Chapter 40 of this title.

(11) "Transact," as used in this chapter, shall not include the organizational activities associated with the preliminary formation, incorporation, petitioning for a certificate of authority, and initial capitalization of a captive insurance company. (Code 1981, § 33-41-2, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-1/HB 552.)

The 2015 amendment, effective July 1, 2015, added present paragraph (5) and redesignated the remaining paragraphs accordingly; and added ", and controlled unaffiliated business" at the end of paragraph (9).

33-41-4. Prerequisites to transacting insurance.

No captive insurance company may transact any insurance in this state unless:

(1) It first obtains from the Commissioner a certificate of authority authorizing it to transact insurance in this state;

(2) It maintains its principal place of business in this state;

(3) Any organization providing the principal administrative or management services to such captive insurance company shall maintain its principal place of business in this state and shall be approved by the Commissioner; and

(4) Its board of directors holds at least one meeting each year in this state. (Code 1981, § 33-41-4, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-2/HB 552.)

The 2015 amendment, effective July 1, 2015, deleted "and" at the end of paragraph (2); inserted "; and" at the end of paragraph (3); and added paragraph (4).

33-41-7. Directors.

(a) The affairs of every captive insurance company shall be managed by not less than three directors.

(b) At least one of the directors of every captive insurance company shall be a resident of this state and a majority of the directors shall be citizens of the United States.

(c) Every captive insurance company shall report to the Commissioner within 30 days after any change in its directors including in its report a statement of the business and professional background and affiliations of any new director. (Code 1981, § 33-41-7, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-3/HB 552.)

The 2015 amendment, effective July 1, 2015, rewrote subsection (b), which formerly read: "At least one-third of the directors of every captive insurance company must be a resident of this state, except that no more than three directors shall be required to be residents of this state. A majority of the directors must be citizens of the United States."; and substituted "shall report" for "must report" in subsection (c).

33-41-8. Amount of capital or surplus.

(a) The amount of minimum capital or surplus required for each captive insurance company shall be determined on an individual basis, however:

(1) A pure captive insurance company shall maintain at least $250,000.00 in surplus;

(2) An association captive insurance company shall maintain at least $500,000.00 in surplus;

(3) An industrial insured captive insurance company shall maintain at least $500,000.00 in surplus; and

(4) A risk retention group shall maintain at least $500,000.00 in surplus.

The Commissioner may require additional capital or surplus of any captive insurance company in an amount he or she deems appropriate under the circumstances based on the captive insurance company's business plan as described in paragraph (2) of subsection (a) of Code Section 33-41-10. Additional capital or surplus may be required if the captive insurance company's business plan indicates that an increase is required in order for the captive insurance company to meet its contractual obligations to its policyholders or to maintain its solvency.

(b) Minimum capital or surplus of up to $500,000.00 shall be maintained in any of the following:

(1) Cash;

(2) Certificates of deposit or similar certificates or evidences of deposits in banks or trust companies but only to the extent that the certificates or deposits are insured by the Federal Deposit Insurance Corporation; or

(3) Savings accounts, certificates of deposit, or similar certificates or evidences of deposit in savings and loan associations and building and loan associations but only to the extent that the same are insured by the Federal Savings and Loan Insurance Corporation.

(c) One hundred thousand dollars of the minimum capital or surplus must be deposited with the state prior to the issuance of a certificate of authority.

(d) Any additional capital or surplus in excess of $500,000.00 required by the Commissioner pursuant to subsection (a) of this Code section may be provided and maintained in any of the following:

(1) Any eligible investments of minimum capital or surplus authorized under Code Section 33-11-5;

(2) Promissory notes or other obligations of shareholders secured by one or more letters of credit, as described in Code Section 33-41-9; or

(3) Any other investments approved by the Commissioner that do not impair the financial solvency of the captive insurance company. (Code 1981, § 33-41-8, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-4/HB 552.)

The 2015 amendment, effective July 1, 2015, rewrote paragraphs (a)(1) and (a)(2); added paragraphs (a)(3) and (a)(4); and, in the first sentence in the undesignated paragraph at the end of subsection (a), inserted "or she" following "he".

33-41-16. Examination by Commissioner or agent; confidentiality.

(a) The Commissioner or his or her designated agent may visit each captive insurance company at any time and examine its affairs in order to ascertain its financial condition, its ability to fulfill its contractual obligations, and its compliance with this chapter. For these purposes, the Commissioner or his or her designated agent shall have free access to all of the books and records relating to the business of the captive insurance company. The expenses and charges of any examination conducted pursuant to this Code section shall be paid directly by the captive insurance company examined.

(b) When necessary or desirable to assist in any examination under this Code section, the Commissioner may retain such independent agents as described in subsection (b) of Code Section 33-41-10, as the Commissioner deems appropriate, in order to facilitate his or her examination under this Code section. The expenses and charges of such persons so retained or designated shall be paid directly by the captive insurance company. The provision of subsection (g) of Code Section 33-2-14 shall apply to examinations of any captive insurance company.

(c) All portions of license applications reasonably designated confidential by or on behalf of an applicant pure captive insurance company, all information and documents, and any copies of the foregoing, produced or obtained by or submitted or disclosed to the Commissioner pursuant to this chapter that are reasonably designated confidential by a pure captive insurance company, and all examination reports, preliminary examination reports, working papers, recorded information, other documents, and any copies of any of the foregoing, produced or obtained by or submitted or disclosed to the Commissioner pursuant to this chapter shall be given confidential treatment, except as to disclosures consented to by the pure captive insurance company, and shall not be subject to subpoena, shall not be made public by the Commis-

sioner, and shall not be provided or disclosed to any other person at any time except to:

(1) Insurance commissioners of any state or of any foreign country or jurisdiction, provided that:

(A) Such receiving party shall agree in writing to maintain the confidentiality of such information; and

(B) The laws of the receiving party require such information to be and to remain confidential; or

(2) A law enforcement official or agency of this state, any other state, or the United States of America so long as such official or agency agrees in writing to hold it confidential and in a manner consistent with this Code section. (Code 1981, § 33-41-16, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-5/HB 552.)

The 2015 amendment, effective July 1, 2015, inserted "or her" following "his" in subsections (a) and (b), added the last sentence in subsection (b); and added subsection (c).

33-41-22. Taxation.

In lieu of any other taxes imposed by this title, all captive insurance companies licensed under this chapter shall pay the following taxes:

(1) A tax at the rate of 0.4 percent on the first $20 million and 0.3 percent on each dollar thereafter on its direct premiums collected, after deducting from the direct premiums subject to the tax the amounts paid to policyholders as return premiums which must include dividends on unabsorbed premiums or premium deposits returned or credited to policyholders;

(2) A tax at the rate of 0.225 percent on the first $20 million of assumed reinsurance premium, and 0.150 percent on the next $20 million and 0.050 percent on the next $20 million, and 0.025 percent of each dollar thereafter. However, no reinsurance tax applies to premiums for risks or portions of risks that are subject to taxation on a direct basis pursuant to paragraph (1) of this Code section. No reinsurance premium tax shall be payable in connection with the receipt of assets in exchange for the assumption of loss reserves and other liabilities of another insurer under common ownership and control, provided that the Commissioner verifies that such transaction is part of a plan to discontinue the operations of such other insurer, and if the intent of the parties to such transaction is to renew or maintain such business with the captive insurance company;

(3) If the aggregate taxes to be paid by a captive insurance company calculated under paragraphs (1) and (2) of this Code section

amount to more than $100,000.00 in any year, the captive insurance company shall pay a maximum tax of $100,000.00 for that year;

(4) Two or more captive insurance companies under common ownership and control shall be taxed as though they were a single captive insurance company; and

(5) The tax provided for in paragraphs (1) and (2) of this Code section shall be calculated on an annual basis, notwithstanding policies or contracts of insurance or contracts of reinsurance issued on a multiyear basis. In the case of multiyear policies or contracts, the premium shall be prorated for purposes of determining the tax due. (Code 1981, § 33-41-22, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-6/HB 552.)

The 2015 amendment, effective July 1, 2015, substituted the present provisions of this Code section for the former provisions, which read: "All captive insurance companies chartered and licensed under this chapter shall be taxed under the provisions of Chapter 8 of this title and any other provisions of law in the same manner as other domestic insurance companies."

CHAPTER 44

HIGH RISK HEALTH INSURANCE PLAN

Delayed effective date. — Ga. L. 1989, p. 1701, § 2, provided that the enactment of this chapter by the Act shall become effective on July 1, 1989, only for the purposes of the appointment of the board of directors and the establishment of elements of the method of operation of the plan by the board. The Act shall become effective for all purposes only upon the appropriation of funds by the General Assembly necessary to carry out the purposes of the Act. No such funds were appropriated during the 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, or 2015 sessions of the General Assembly.

CHAPTER 45

CONTINUING CARE PROVIDERS AND FACILITIES

33-45-1. Definitions.

As used in this chapter, the term:

(1) "Continuing care" means furnishing pursuant to a continuing care agreement:

(A) Lodging that is not:

(i) In a skilled nursing facility, as such term is defined in paragraph (34) of Code Section 31-6-2;

(ii) An intermediate care facility, as such term is defined in paragraph (22) of Code Section 31-6-2;

(iii) An assisted living community, as such term is defined in Code Section 31-7-12.2; or

(iv) A personal care home, as such term is defined in Code Section 31-7-12;

(B) Food; and

(C) Nursing care provided in a facility or in another setting designated by the agreement for continuing care to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee including skilled or intermediate nursing services and, at the discretion of the continuing care provider, personal care services including, without limitation, assisted living care services designated by the continuing care agreement, including such services being provided pursuant to a contract to ensure the availability of such services to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee.

Such term shall not include continuing care at home.

(2) "Continuing care agreement" means a contract or agreement to provide continuing care, continuing care at home, or limited continuing care. Continuing care agreements include agreements to provide care for any duration, including agreements that are terminable by either party.

(2.1) "Continuing care at home" means the furnishing of services pursuant to a continuing care agreement at a location other than at a facility and which includes the obligation to provide nursing care, assisted living care, or personal care home services. A continuing care at home agreement may, but is not required to, include an obligation to provide food.

(3) "Entrance fee" means an initial or deferred payment of a sum of money or property made as full or partial payment to assure the

resident continuing care, limited continuing care, or continuing care upon the purchase of a resident owned living unit; provided, however, that any such initial or deferred payment which is greater than or equal to 12 times the monthly care fee shall be presumed to be an entrance fee so long as such payment is intended to be a full or partial payment to assure the resident lodging in a residential unit. An accommodation fee, admission fee, or other fee of similar form and application greater than or equal to 12 times the monthly care fee shall be considered to be an entrance fee. Such term shall not include any portion of the purchase or sale of a resident owned living unit.

(4) "Facility" means a place which is owned or operated by a provider and provides continuing care or limited continuing care. Such term includes a facility which contains resident owned living units.

(5) "Licensed" means that the provider has obtained a certificate of authority from the department.

(6) "Limited continuing care" means furnishing pursuant to a continuing care agreement:

(A) Lodging that is not:

(i) In a skilled nursing facility, as such term is defined in paragraph (34) of Code Section 31-6-2;

(ii) An intermediate care facility, as such term is defined in paragraph (22) of Code Section 31-6-2;

(iii) An assisted living community, as such term is defined in Code Section 31-7-12.2; or

(iv) A personal care home, as such term is defined in Code Section 31-7-12;

(B) Food; and

(C) Personal services, whether such personal services are provided in a facility such as a personal care home or an assisted living community or in another setting designated by the continuing care agreement, to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee.

Such term shall not include continuing care at home.

(7) "Monthly care fee" means the fee charged to a resident for continuing care or limited continuing care on a monthly or periodic basis. Monthly care fees may be increased by the provider to provide care to the resident as outlined in the continuing care agreement.

Periodic fee payments or other prepayments shall not be monthly care fees.

(8) "Nursing care" means services which are provided to residents of skilled nursing facilities or intermediate care facilities.

(9) "Personal services" means, but is not limited to, such services as individual assistance with eating, bathing, grooming, dressing, ambulation, and housekeeping; supervision of self-administered medication; arrangement for or provision of social and leisure services; arrangement for appropriate medical, dental, nursing, or mental health services; and other similar services which the department may define. Personal services may be provided at a facility or at a home on or off site of a facility. Personal services shall not be construed to mean the provision of medical, nursing, dental, or mental health services. Personal services provided, if any, shall be designated in the continuing care agreement.

(10) "Provider" means the owner or operator, whether a natural person, partnership, or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, which owner or operator undertakes to provide continuing care, limited continuing care, or continuing care at home for a fixed or variable fee, or for any other remuneration of any type for the period of care, payable in a lump sum or lump sum and monthly maintenance charges or in installments.

(11) "Resident" means a purchaser of or a nominee of or a subscriber to a continuing care agreement. Such an agreement may permit a resident to live at a home on or off site of a facility but shall not be construed to give the resident a part ownership of the facility in which the resident is to reside unless expressly provided for in the agreement.

(12) "Resident owned living unit" means a residence or apartment, the purchase or sale of which is not included in an entrance fee, which is a component part of a facility and in which the resident has an individual real property ownership interest.

(13) "Residential unit" means a residence or apartment in which a resident lives that is not a skilled nursing facility as defined in paragraph (34) of Code Section 31-6-2, an intermediate care facility as defined in paragraph (22) of Code Section 31-6-2, an assisted living community as defined in Code Section 31-7-12.2, or a personal care home as defined in Code Section 31-7-12. (Code 1981, § 33-45-1, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2014, p. 375, § 1/SB 304; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2015, p. 581, § 1/SB 111.)

The 2014 amendment, effective July 1, 2014, rewrote this Code section.

The 2015 amendments. — The first 2015 amendment, effective March 13, 2015, part of an Act to revise, modernize, and correct the Code, redesignated paragraphs (12) and (13) as paragraphs (13) and (12), respectively, in order to place the respective definitions in alphabetical order. The second 2015 amendment, effective July 1, 2015, added the undesignated language at the end of paragraph (1); substituted ", continuing care at home, or limited continuing care. Continuing care agreements" for "or limited continuing care. Agreements to provide continuing care or limited continuing care" in paragraph (2); added paragraph (2.1); added the undesignated language at the end of paragraph (6); inserted the second sentence in paragraph (9); substituted "care, limited continuing care, or continuing care at home" for "care or limited continuing care" in paragraph (10); and inserted "may permit a resident to live at a home on or off site of a facility but" in paragraph (11).

33-45-3. Certificate of authority required for operation of continuing care facilities.

(a) Nothing in this title or chapter shall be deemed to authorize any provider to transact any insurance business other than that of continuing care insurance or limited continuing care insurance or otherwise to engage in any other type of insurance unless it is authorized under a certificate of authority issued by the department under this title. Nothing in this chapter shall be construed so as to interfere with the jurisdiction of the Department of Community Health or any other regulatory body exercising authority over providers regulated by this chapter or real property law related to the purchase and sale of resident owned living units.

(b) Nothing in this chapter shall be construed so as to modify or limit in any way:

(1) Provisions of Article 3 of Chapter 6 of Title 31 and any rules and regulations promulgated by the Department of Community Health pursuant to such article relating to certificates of need for continuing care retirement communities or home health agencies, as such terms are defined in Code Section 31-6-2; or

(2) Provisions of Chapter 7 of Title 31 relating to licensure or permit requirements and any rules and regulations promulgated by the Department of Community Health pursuant to such chapter, including, without limitation, licensure or permit requirements for nursing home care, assisted living care, personal care home services, home health services, and private home care services.

(c) Nothing in this chapter shall be construed so as to allow private home care services to be provided by any person or entity other than a licensed private home care provider.

(d) A provider of continuing care at home may contract with a licensed home health agency to provide home health services to a

resident. In order to provide home health services directly, a provider of continuing care at home shall obtain a certificate of need for a home health agency, as such term is defined in paragraph (20) of Code Section 31-6-2, pursuant to the same criteria and rules as are applicable to freestanding home health agencies that are not components of continuing care retirement communities. (Code 1981, § 33-45-3, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 1999, p. 296, § 22; Ga. L. 2000, p. 136, § 33; Ga. L. 2009, p. 453, § 1-43/HB 228; Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2014, p. 375, § 2/SB 304; Ga. L. 2015, p. 581, § 2/SB 111.)

The 2014 amendment, effective July 1, 2014, added the subsection (a) designation, and, in subsection (a), deleted "of a continuing care facility or a facility providing limited continuing care" following "authorize any provider" near the beginning of the first sentence, and in the second sentence, deleted "continuing care providers or limited continuing care" following "authority over" near the end, and added "or real property law related to the purchase and sale of resident owned living units" at the end; and added subsection (b).

The 2015 amendment, effective July 1, 2015, added subsections (c) and (d).

33-45-7. Requirements for continuing care agreements, addenda, and amendments.

(a) In addition to other provisions considered proper to effectuate any continuing care agreement, addendum, or amendment, each such agreement, addendum, or amendment shall be in writing and shall:

(1) Provide for the continuing care or limited continuing care of only one resident, or for two persons occupying space designed for double occupancy under appropriate regulations established by the provider, and shall state the total consideration to be paid, including a list of all properties transferred and their market value at the time of transfer, including donations, subscriptions, fees, and any other amounts paid or payable by, or on behalf of, the resident or residents;

(2) Specify all services which are to be provided by the provider to each resident, including, in detail, all items which each resident will receive, whether the items will be provided for a designated time period or for life, and whether the services will be available on the premises or at another specified location. The provider shall indicate which services or items are included in the monthly care fee and which services or items are made available at or by the facility at extra charge. Such items may include, but are not limited to, food, lodging, personal services or nursing care, drugs, burial, and incidentals;

(3) Describe the terms and conditions under which the continuing care agreement may be canceled by the provider or by a resident and the conditions, if any, under which all or any portion of the entrance fee will be refunded in the event of cancellation of the continuing care

agreement by the provider or by the resident, including the effect of death of or any change in the health or financial condition of a person between the date of entering a continuing care agreement and the date of initial occupancy of a residential unit by that person;

(4) Describe:

(A) The residential unit;

(B) Any property rights of the resident;

(C) The health and financial conditions required for a person to be accepted as a resident and to continue as a resident, once accepted, including the effect of any change in the health or financial condition of a person between the date of entering into a continuing care agreement and the date of taking occupancy in a residential unit;

(D) The conditions under which a residential unit occupied by a resident may be made available by the provider to a different or new resident other than on the death of the prior resident;

(E) The policies to be implemented and the circumstances under which the resident will be permitted to remain in the facility in the event of financial difficulties of the resident; and

(F) The procedures the provider shall follow to change the resident's accommodation if necessary for the protection of the health or safety of the resident or of the general and economic welfare of the facility;

(5) State the fees that will be charged if the resident marries while at the designated facility, the terms concerning the entry of a spouse to the facility, and the consequences if the spouse does not meet the requirements for entry;

(6) State whether the funds or property transferred for the care of the resident is:

(A) Nonrefundable, in which event the continuing care agreement shall comply with this subparagraph. Such continuing care agreement shall allow a 90 day trial period of residency in the facility during which time the provider, resident, or person who provided the transfer of funds or property for the care of such resident may cancel the agreement after written notice. A refund shall be made of such funds, property, or both within 120 days after the receipt of such notice and shall be calculated on a pro rata basis with the provider retaining no more than 10 percent of the amount of the entry fee. Notwithstanding the provisions of this subparagraph, the provisions of paragraph (7) of this subsection and the

provisions of subsections (b) and (e) of this Code section shall apply to nonrefundable continuing care agreements; or

(B) Refundable, in which event the continuing care agreement shall comply with this subparagraph. Such continuing care agreement may be canceled upon the giving of written notice of cancellation of at least 30 days by the provider, the resident, or the person who provided the transfer of property or funds for the care of such resident; provided, however, that if a continuing care agreement is canceled because there has been a good faith determination that a resident is a threat to his or her health or safety or to the health or safety of others, only such notice as is reasonable under the circumstances shall be required. The continuing care agreement shall further provide in clear and understandable language, in print no smaller than the largest type used in the body of the continuing care agreement, the terms governing the refund of any portion of the entrance fee, which terms shall include a provision that all refunds be made within 120 days of notification. The moneys refunded to the resident may be from the escrow account required by Code Section 33-45-8 or from other funds available to the provider, and the continuing care agreement shall further comply with the following requirements:

(i) For a resident whose continuing care agreement with the facility provides that the resident does not receive a transferable membership or ownership right in the facility and who has occupied his or her residential unit, the refund shall be calculated on a pro rata basis with the facility retaining no more than 2 percent per month of occupancy by the resident and no more than a 4 percent fee for processing. Such refund shall be paid no later than 120 days after the giving of notice of intention to cancel; or

(ii) If the continuing care agreement provides for the facility to retain no more than 1 percent per month of occupancy by the resident, it may provide that such refund will be payable upon receipt by the provider of the next entrance fee for any comparable residential unit upon which there is no prior claim by any resident; provided, however, that the agreement may define the term "comparable residential unit upon which there is no prior claim"; specifically delineate when such refund is due; and establish the order of priority of refunds to residents. Unless the provisions of subsection (e) of this Code section apply, for any prospective resident, except when such resident receives a transferable membership or ownership right in a resident owned living unit, who cancels the agreement prior to occupancy of the residential unit, the refund shall be the entire amount paid

toward the entrance fee, less a processing fee not to exceed 4 percent of the entire entrance fee, but in no event shall such processing fee exceed the amount paid by the prospective resident. Such refund shall be paid no later than 60 days after the giving of notice of intention to cancel. For a resident who has occupied his or her residential unit and who has received a transferable membership or ownership right in the facility, the foregoing refund provisions shall not apply but shall be deemed satisfied by the acquisition or receipt of a transferable membership or an ownership right in the facility. The provider shall not charge any fee for the transfer of membership or sale of an ownership right. Nothing in this paragraph shall be construed to require a continuing care agreement to provide a refund to more than one resident at a time upon the vacation of a specific comparable residential unit;

(7) State the terms under which a continuing care agreement is canceled by the death of the resident. These terms may contain a provision that, upon the death of a resident, the entrance fee of such resident shall be considered earned and shall become the property of the provider. When the unit is shared, the conditions with respect to the effect of the death or removal of one of the residents shall be included in the continuing care agreement;

(8) Require:

(A) The continuing care agreement to provide for advance notice to the resident, of not less than 60 days, before any change in fees or charges or the scope of care or services may be effective, except for changes required by state or federal assistance programs;

(B) A description of the manner by which the provider may adjust periodic charges or other recurring fees and the limitations on these adjustments, if any; and

(C) A description of any policy regarding fee adjustments if the resident is voluntarily absent from the facility;

(9) Provide that charges for care paid in one lump sum shall not be increased or changed during the duration of the agreed upon care, except for changes required by state or federal assistance programs; and

(10) Describe the policy of the provider regarding reserve funding.

(b) Notwithstanding the provisions of subparagraph (a)(6)(A) of this Code section, a resident has the right to rescind a continuing care agreement, without penalty or forfeiture, within seven days after executing such continuing care agreement. During the seven-day period, the resident's funds shall be retained in an escrow account in

accordance with the provisions of subsection (a) of Code Section 33-45-8. A resident shall not be required to move into the facility designated in the continuing care agreement before the expiration of the seven-day period. In the event that the prospective resident exercises his or her right to rescind the continuing care agreement within seven days of executing such continuing care agreement, the facility shall return any portion of the entrance fee paid by the resident within 30 days of receipt of the prospective resident's notice of rescission.

(c) The continuing care agreement shall include or shall be accompanied by a statement, printed in boldface type, which reads: "This facility and all continuing care agreements in this state are regulated by Chapter 45 of Title 33 of the Official Code of Georgia Annotated. A copy of the law is on file in this facility. The law gives you or your legal representative the right to inspect our most recent disclosure statement before signing the agreement."

(d) Before the transfer of any money or other property, other than an application fee which shall not exceed $1,500.00, to a provider by or on behalf of a prospective resident, the provider shall present a typewritten or printed copy of the continuing care agreement and the disclosure statement required pursuant to Code Section 33-45-10 to the prospective resident and all other parties to the agreement. The provider shall secure a signed, dated statement from each party to the contract certifying that a copy of the continuing care agreement and the disclosure statement was received.

(e) If a resident dies before occupying the facility or, through illness, injury, or incapacity, is precluded from becoming a resident under the terms of the continuing care agreement, the agreement shall be automatically canceled, and the resident or his or her legal representative shall receive a full refund of all moneys paid to the facility, except those costs specifically incurred by the facility at the request of the resident and set forth in writing in a separate addendum, signed by both parties, to the agreement.

(f) In order to comply with this Code section, a provider may furnish information not contained in the continuing care agreement through an addendum.

(g) The Commissioner may also require the provider to submit to him or her a copy of the continuing care agreement generally used by the provider; provided, however, that nothing in this subsection shall prohibit the department from requiring the submission of an individual contract between the provider and the resident. (Code 1981, § 33-45-7, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2012, p. 775, § 33/HB 942; Ga. L. 2014, p. 375, § 3/SB 304.)

The 2014 amendment, effective July 1, 2014, substituted "except when such resident receives a transferable membership or ownership right in a resident owned living unit" for "regardless of whether or not such resident receives a transferable membership or ownership right in the facility" in the second sentence of division (a)(6)(B)(ii).

33-45-7.1. Provider authorized to offer continuing care when resident purchases resident owned living unit.

A provider which has obtained a certificate of authority pursuant to Code Section 33-45-5 and the written approval of the commissioner is authorized to offer, as a part of the continuing care agreement, continuing care at home or continuing care in which the resident purchases a resident owned living unit, subject to the provisions of Chapters 6 and 7 of Title 31 and rules and regulations promulgated by the Department of Community Health pursuant to such chapters relating to certificate of need and licensure requirements. (Code 1981, § 33-45-7.1, enacted by Ga. L. 2014, p. 375, § 4/SB 304; Ga. L. 2015, p. 581, § 3/SB 111.)

Effective date. — This Code section became effective July 1, 2014.

The 2015 amendment, effective July 1, 2015, inserted "continuing care at home or" near the middle of this Code section.

33-45-10. Information disclosure requirements.

(a) Each facility shall maintain as public information, available upon request, a copy of its current disclosure statement and the disclosure and all previous disclosure statements that have been filed with the department. Each facility shall post in a prominent position in the facility, so as to be accessible to all residents and to the general public, a notice explaining where such disclosure statements may be viewed. In conjunction with the disclosure statement, the facility shall notify residents of any proposed changes in policies, programs, and services.

(b) Each facility shall post in a prominent position in the facility so as to be accessible to all residents and to the general public a brief summary of the disclosure statement required pursuant to subsection (a) of this Code section, indicating in the summary where the full disclosure statement may be inspected in the facility. A listing of any proposed changes in policies, programs, and services shall also be posted.

(c) Before entering into a continuing care agreement to furnish continuing care or at the time of, or prior to, the transfer of any money or other property to a provider by or on behalf of a prospective resident, whichever occurs first, the provider undertaking to furnish the care, or the agent of the provider, shall provide the current disclosure statement required pursuant to subsection (a) of this Code section and copies to

the prospective resident, or his or her legal representative, of the continuing care agreement.

(d) The text of the disclosure statement required by this Code section shall contain at least:

(1) The name and business address of the provider and a statement as to whether the provider is a partnership, corporation, or other type of legal entity;

(2) The names and business addresses and description of the business experience of the person, if any, in the operation or management of similar facilities of the officers, directors, trustees, managing or general partners, any person having a 10 percent or greater equity or beneficial interest in the provider, and any person who will be managing the facility on a day to day basis and a description of these persons' interests in or occupations with the provider;

(3) Information on all persons named in response to paragraph (2) of this subsection which details:

(A) Any conflict or potential conflict of interest; and

(B) Any relevant criminal record, including a plea of nolo contendere, background on relevant civil judicial proceedings, and relevant action brought by a governmental agency or department, if the order or action arose out of or related to business activity of health care;

(4) A statement as to whether the provider is or is not affiliated with a religious, charitable, or other nonprofit organization; the extent of the affiliation, if any; the extent to which the affiliate organization will be responsible for the financial and contract obligations of the provider; and the provision of the Federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of income tax;

(5) An estimate of the number of residents of the facility to be provided services;

(6) The location and description of the physical property or properties of the facility, existing or proposed, and to the extent proposed, the estimated completion date or dates, whether construction has begun, and the contingencies subject to which construction may be deferred;

(7) The location of other facilities, if any, which the provider owns or operates;

(8) A statement that the provider maintains financial reserves in conformance with the requirements of Code Section 33-45-11 or

otherwise meets the requirements of that Code section; the provisions that the provider has made or will make to provide reserve funding or security to enable the provider to perform its obligations fully under continuing care agreements to provide continuing care or limited continuing care at the facility, including the establishment of escrow accounts, trusts, or reserve funds, together with the manner in which these funds will be invested; and the names and experience of any individuals in the direct employment of the provider who will make the investment decisions;

(9) A financial statement audited by an independent certified public accountant which shall provide the information required by this Code section for two or more fiscal years if the facility has been in existence that long. If the facility has been in existence for a lesser length of time, the financial statements of the provider shall be for the most recent fiscal year or such shorter period of time as the provider shall have been in existence. If the provider's fiscal year ended more than 120 days prior to the date the disclosure statement is recorded, interim financial statements as of a date not more than 90 days prior to the date of recording the statement shall also be included but need not be certified to by an independent certified public accountant. The financial statement shall contain the following:

(A) An accountant's opinion and, in accordance with generally accepted accounting principles:

(i) A balance sheet;

(ii) A statement of income and expenses;

(iii) A statement of equity or fund balances; and

(iv) A statement of changes in financial position; and

(B) Notes to the financial statements considered customary or necessary for full disclosure or adequate understanding of the financial statements, financial condition, and operation and additional costs to the resident;

(10) The level of participation in medicare or Medicaid programs, or both; and

(11) A statement concerning all fees required of residents, including, but not limited to:

(A) A statement of the entrance fee charged, the monthly service charges, the proposed application of the proceeds of the entrance fee by the provider, and the plan by which the amount of the entrance fee is determined if the entrance fee is not the same in all cases; and

(B) A record of past increases in entrance fees and monthly care fees and other similar charges during the previous three years;

(12) If a facility is in a stage of being proposed or developed, it shall additionally provide:

(A) The summary of the report of an actuary estimating the capacity of the provider to meet its contractual obligation to the residents; and

(B) A statement of cash flows and narrative disclosure detailing all significant assumptions used in the preparation of the statement of cash flows. The Commissioner may establish by rule or regulation the necessary and significant assumptions used in the preparation of the statements of cash flow; and

(13) Any additional costs to the resident.

(e) The cover page of the disclosure statement shall state, in a prominent location and in boldface type, the date of the disclosure statement, the last date through which the disclosure statement may be delivered if not earlier revised, and that the delivery of the disclosure statement to a contracting party before the execution of a continuing care agreement is required by this chapter, but that the disclosure statement has not been reviewed or approved by any government agency or representative to ensure accuracy or completeness of the information set out.

(f) A copy of the continuing care agreement generally used by the provider shall be attached to each disclosure statement.

(g) The Commissioner may prescribe a standardized format for the disclosure statement required by this Code section.

(h) The department may require a provider to alter or amend its disclosure statement in order to provide full and fair disclosure to prospective residents. The department may also require the revision of a disclosure statement which it finds to be unnecessarily complex, confusing, or illegible. (Code 1981, § 33-45-9, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-10, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2014, p. 375, § 5/SB 304.)

The 2014 amendment, effective July 1, 2014, added the second and third sentences to subsection (a).

CHAPTER 57

CONSUMERS' INSURANCE ADVOCATE

Sec.
33-57-1 through 33-57-8. [Repealed].

33-57-1 through 33-57-8.

Reserved. Repealed by Ga. L. 2015, p. 1088, § 24/SB 148, effective July 1, 2015.

Editor's notes. — This chapter was based on Code 1981, § 33-57-1, enacted by Ga. L. 1999, p. 335, § 2; Ga. L. 2000, p. 1589, § 3; Ga. L. 2012, p. 701, § 2/HB 786.

CHAPTER 63

GUARANTEED ASSET PROTECTION WAIVERS

Sec.
33-63-3. Definitions.

33-63-3. Definitions.

The following terms are defined for purposes of this chapter and are not intended to provide actual terms required in guaranteed asset protection waivers:

(1) "Administrator" means a person, other than an insurer or creditor, that performs administrative or operational functions pursuant to guaranteed asset protection waiver programs.

(2) "Borrower" means a debtor, retail buyer, or lessee under a finance agreement.

(3) "Creditor" means:

(A) The lender in a loan or credit transaction;

(B) The lessor in a lease transaction;

(C) Any retail installment seller that provides credit to any retail buyer of motor vehicles, provided that such entity complies with the provisions of this chapter;

(D) The seller in commercial retail installment transactions; or

(E) The assignees of any of the creditors listed in subparagraphs (A) through (D) of this paragraph to whom the credit obligation is payable.

(4) "Finance agreement" means a loan, lease, or retail installment sales contract for the purchase or lease of a motor vehicle.

(5) "Free look period" means the period of time from the effective date of the guaranteed asset protection waiver until the date the borrower may cancel the guaranteed asset protection waiver without penalty, fees, or costs to the borrower. This period of time must not be shorter than 30 days.

(6) "Guaranteed asset protection waiver" means a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive all or part of amounts due on a borrower's finance agreement in the event of a total physical damage loss or unrecovered theft of the motor vehicle, which agreement must be part of, or a separate addendum to, the finance agreement or a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive all or part of the excess wear and use charges owed by the borrower to the creditor under the lease contract when the borrower returns a leased vehicle to the creditor at termination of the lease, which agreement must be part of, or a separate addendum to, the lease contract.

(7) "Insurer" means an insurance company licensed, registered, or otherwise authorized to do business under the insurance laws of this state.

(8) "Motor vehicle" means self-propelled or towed vehicles designed for personal or commercial use, including but not limited to automobiles, trucks, motorcycles, recreational vehicles, all-terrain vehicles, campers, boats, personal watercraft, and motorcycle, boat, camper, and personal watercraft trailers.

(9) "Person" includes an individual, company, association, organization, partnership, business trust, corporation, and every form of legal entity.

(10) "Retail buyer" shall have the same meaning as provided in Code Section 10-1-31.

(11) "Retail installment seller" shall have the same meaning as provided in Code Section 10-1-31. (Code 1981, § 33-63-3, enacted by Ga. L. 2008, p. 1097, § 1/SB 470; Ga. L. 2014, p. 181, § 6/HB 610.)

The 2014 amendment, effective July 1, 2014, added the language beginning "or a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive all or part of the excess wear" at the end of paragraph (6).

CHAPTER 64

REGULATION AND LICENSURE OF PHARMACY BENEFITS MANAGERS

33-64-1. (For effective date, see note.) Definitions.

As used in this chapter, the term:

(1) "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(2) "Commissioner" means the Commissioner of Insurance.

(3) "Covered entity" means an employer, labor union, or other group of persons organized in this state that provides health coverage to covered individuals who are employed or reside in this state.

(4) "Covered individual" means a member, participant, enrollee, contract holder, policy holder, or beneficiary of a covered entity who is provided health coverage by a covered entity.

(5) "Health system" means a hospital or any other facility or entity owned, operated, or leased by a hospital and a long-term care home.

(6) "Maximum allowable cost" means the per unit amount that a pharmacy benefits manager reimburses a pharmacist for a prescription drug, excluding dispensing fees and copayments, coinsurance, or other cost-sharing charges, if any.

(7) "Pharmacy" means a pharmacy or pharmacist licensed pursuant to Chapter 4 of Title 26 or another dispensing provider.

(8) "Pharmacy benefits management" means the service provided to a health plan or covered entity, directly or through another entity, including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits, including, but not limited to, any of the following:

(A) Mail order pharmacy;

(B) Claims processing, retail network management, or payment of claims to pharmacies for dispensing prescription drugs;

(C) Clinical or other formulary or preferred drug list development or management;

(D) Negotiation or administration of rebates, discounts, payment differentials, or other incentives for the inclusion of particular prescription drugs in a particular category or to promote the purchase of particular prescription drugs;

(E) Patient compliance, therapeutic intervention, or generic substitution programs; and

(F) Disease management.

(9) "Pharmacy benefits manager" means a person, business entity, or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. The term does not include services provided by pharmacies operating under a hospital pharmacy license. The term also does not include health systems while providing pharmacy services for their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for outpatient procedures. The term also does not include services provided by pharmacies affiliated with a facility licensed under Code Section 31-44-4 or a licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110. (Code 1981, § 33-64-1, enacted by Ga. L. 2010, p. 757, § 1/SB 310; Ga. L. 2015, p. 337, § 2/HB 470.)

Delayed effective date. — This Code section, as set out above, becomes effective January 1, 2016. For version of this Code section in effect until January 1, 2016, see the 2015 amendment note.

The 2015 amendment, effective January 1, 2016, added present paragraphs (6) and (7) and redesignated former paragraphs (6) and (7) as present paragraphs (8) and (9), respectively; in subparagraph (8)(A), substituted "order" for "service", and added the last sentence of paragraph (9).

33-64-7. (For effective date, see note.) Commissioner not authorized to extend rules and regulations; Commissioner authorized to enforce provisions of chapter.

The Commissioner may not enlarge upon or extend the provisions of this chapter through any act, rule, or regulation; provided, however, that the Commissioner is authorized to enforce any provision of this chapter. (Code 1981, § 33-64-7, enacted by Ga. L. 2010, p. 757, § 1/SB 310; Ga. L. 2015, p. 337, § 3/HB 470.)

Delayed effective date. — This Code section, as set out above, becomes effective January 1, 2016. For version of this Code section in effect until January 1, 2016, see the 2015 amendment note.

The 2015 amendment, effective January 1, 2016, added "; provided, however, that the Commissioner is authorized to enforce any provision of this chapter" at the end of this Code section.

33-64-9. (Effective January 1, 2016) Requirements for use of maximum allowable cost pricing by pharmacy benefits managers; appeals; enforcement authority.

(a) Upon each contract execution or renewal between a pharmacy benefits manager and a pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, a pharmacy benefits manager shall, with respect to such contract or renewal:

(1) Include in such contract or renewal the sources utilized to determine multi-source generic drug pricing, such as maximum allowable cost or any successive benchmark pricing formula, and update such pricing information at least every five business days, provided that such pricing information update shall be at least every 14 business days for those contracts pursuant to Article 7 of Chapter 4 of Title 49; and

(2) Maintain a procedure to eliminate products from the multi-source generic list of drugs subject to such pricing or modify multi-source generic drug pricing within five business days when such drugs do not meet the standards and requirements of this Code section in order to remain consistent with pricing changes in the marketplace.

(b) A pharmacy benefits manager shall reimburse pharmacies for drugs subject to multi-source generic drug pricing based upon pricing information which has been updated within five business days as set forth in paragraph (1) of subsection (a) of this Code section.

(c) A pharmacy benefits manager may not place a drug on a multi-source generic list unless there are at least two therapeutically equivalent, multi-source generic drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers.

(d) All contracts between a pharmacy benefits manager and a contracted pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, shall include a process to internally appeal, investigate, and resolve disputes regarding multi-source generic drug pricing. The process shall include the following:

(1) The right to appeal shall be limited to 14 calendar days following reimbursement of the initial claim; and

(2) A requirement that the health benefit plan issuer or pharmacy benefits manager shall respond to an appeal described in subsection (a) of this Code section no later than 14 calendar days after the date the appeal was received by such health benefit plan issuer or pharmacy benefits manager.

(e) For appeals that are denied, the pharmacy benefits manager shall provide the reason for the denial and identify the national drug code of a drug product that may be purchased by contracted pharmacies at a price at or below the maximum allowable cost.

(f) If the appeal is successful, the health benefit plan issuer or pharmacy benefits manager shall:

(1) Adjust the maximum allowable cost price that is the subject of the appeal effective on the day after the date the appeal is decided;

(2) Apply the adjusted maximum allowable cost price to all similarly situated pharmacists and pharmacies as determined by the health plan issuer or pharmacy benefits manager; and

(3) Allow the pharmacist or pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefits claim giving rise to the appeal.

(g) Appeals shall be upheld if:

(1) The pharmacy being reimbursed for the drug subject to the multi-source generic drug pricing in question was not reimbursed as required in subsection (b) of this Code section; or

(2) The drug subject to the multi-source generic drug pricing in question does not meet the requirements set forth in subsection (c) of this Code section.

(h) The Commissioner shall have enforcement authority over this Code section. (Code 1981, § 33-64-9, enacted by Ga. L. 2015, p. 337, § 4/HB 470.)

Effective date. — This Code section becomes effective January 1, 2016.